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Montana Health Agenda

"To improve and protect the health and safety of all Montanans"

MONTANA
Department of Public Health & Human Services

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MONTANA HEALTH AGENDA

STATE OF MONTANA
MARC RACICOT, GOVERNOR

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
LAURIE EKANGER, DEPARTMENT DIRECTOR

HEALTH POLICY AND SERVICES DIVISION
NANCY ELLERY, DIVISION ADMINISTRATOR

Helena, Montana
April 1998

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DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
HEALTH POLICY & SERVICES DIVISION

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STATE OF MONTANA

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April 1998

Dear fellow Montanans:

It is my privilege to introduce the **Montana Health Agenda**, a culmination of the efforts of planners, program managers, and health professionals throughout Montana.

The **Montana Health Agenda** has been developed as a road map for health service and program action, particularly as it relates to the department's Health Policy and Services Division (HPSD). HPSD houses the department's public health programs and Medicaid acute and primary care services. Therefore, its major focus is on health in Montana—both public health and health service delivery.

Montana's state and local public health agencies do more than provide immunizations and assure the safety of our food and water. These agencies are the "safety nets" that protect the health of Montanans—preventing disease, injury, disability, and early death; complementing private health care systems; and "filling the gaps" as public and private health care systems evolve.

The reorganization of DPHHS has provided the opportunity for public health, Medicaid, and social service agencies to work more closely than ever before. State and local health and human service agencies are working with health care providers and other state and local decision makers to ensure that the systems, oversight, and resources needed to fulfill the DPHHS mission are available to all Montanans.

To be cost-effective and take advantage of changes in health care technology, service delivery, and medical innovation, health planning must have state and national components. However, assessing, planning for, and assuring the health of the public is a **local** function. Public health is the safety net for **your** community. Medicaid providers are **your** doctors, nurses, hospitals, clinics, and nursing homes. The success of this agenda depends on what takes place in each Montana community.

Thank you for your interest and involvement in the **Health Agenda**. With all of our efforts, state and local health agencies will continue playing a pivotal and essential role in the health and safety of Montanans.

Sincerely,

Laurie Ekanger

Laurie Ekanger
Director

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EXECUTIVE SUMMARY

MONTANA'S MISSION AND AGENDA FOR HEALTH:

- The **Montana Health Agenda** is the **Health Policy and Services Division's (HPSD)** plan to fulfill the mission it shares with many partners in public and private organizations across the state. This agenda **identifies the highest priority issues** for the health and safety of Montana's citizens and visitors. It establishes **goals** that Montana will move toward over the next **five to 10 years**. The **objectives** outlined identify the **milestones** HPSD and its partners plan to achieve in the **next two to five years**.

The issues, goals, and objectives identified in the **Health Agenda** align with the missions of both the **Department of Public Health and Human Services** (DPHHS) and **HPSD**:

- The **DPHHS mission — To improve, preserve, strengthen and protect the health, well-being, and self-reliance of all Montanans.**
- The **HPSD mission — To improve and protect the health and safety of Montanans.**

PRIORITIES FOR HEALTHY MONTANANS:

Public agencies would like to address all of the major health issues in the populations they serve. However, practical considerations of time and resource availability place constraints on what and how much can be done. Those considerations lead public and private health professionals to establish priorities, defining for ourselves and our citizenry the issues and needs that will guide state and local planning efforts for the next five to 10 years. These priorities must include improving the health systems themselves to make sure that health improvements are universally effective and lasting.

In two planning workshops, HPSD staff brought together the results of statewide, program-based needs assessment and planning efforts. Workshop attendees identified the following highest-priority issues and goals. This **Health Agenda** is a first effort. Thus, these issues are not all-encompassing: the **Health Agenda** does not include environmental health issues, many issues relating to mental health and addictive behaviors, or those involving direct services to older or disabled Montanans. The issues below include those which directly involve the division's programs and staff and which HPSD and its partners have identified as having the greatest impact on Montanans.

Cardiovascular Disease
Cancer
Unintentional Injury
Pregnancy Outcomes
Child and Adolescent Health
Unintended Pregnancies
Diabetes
Sexually Transmitted Diseases
HIV/AIDS Treatment
Food Safety
Emergency Medical Services
Public Health Laboratory
Access to Health Care
Managed Care
Public Health Improvement
Information Access and Security

BEHIND EACH MONTANA PRIORITY:

Identifying the major issues is only the first step. For each priority, this report presents insights on how current conditions are tied to future objectives and how Montanans in and outside state and local government have worked and will work together to accomplish our objectives. Five elements make up each priority discussion:

• Goal and Objectives	Identification of each priority issue and its related benchmarks
• Why It's Important	Background information about the priority issue
• What Montana Has Accomplished	Major milestones already achieved
• What Still Needs to be Done	Action needed to accomplish the objectives
• Where It Will Be Done	Responsibility, partnerships, and agencies involved

Montana's long-term aims are significant advances in the health, safety, and quality of life of both citizens and visitors. In setting these objectives, each priority issue team worked to define reasonable, responsible—including cost-effective—actions that public agencies and their community partners could take to achieve the goal. In some cases, a national objective was adopted because comparison to other states or national standards provides a frame of reference for measuring performance. In other cases, national objectives are inappropriate when applied to a northwestern, rural population or do not serve as good benchmarks given Montana's current health status or health service resources.

Ultimately, this agenda sets forth objectives that are appropriate to Montana's unique circumstances, resources, and needs. Because these objectives are **measurable**, they provide a mechanism for monitoring progress toward the goals and making mid-course adjustments when necessary. Each objective represents a **feasible** milestone but not an easy one. It will take a statewide partnership to accomplish these objectives.

PARTNERS: THE KEYS TO SUCCESS

Public health involves the public in providing for its own protection. Social and health services depend on the societies they serve to define and clarify their roles. Fulfilling these functions brings together members of the public, private and public health professionals, and concerned leaders in government, business, education, the work force, religion, and public service. In developing the Health Agenda, HPSD has depended on this broad range of collaborators to share in identifying and carrying out the steps needed to achieve our mutual objectives. The following agencies, organizations, and groups broadly represent HPSD's partners:

Local Government Agencies or Contractors
- County and City-County Health Departments
- Other Local Health Agencies
- Hunger/Nutrition Councils
- School Districts and Schools
- Early Childhood Services
- Social Service Providers
- Tribal Health Departments or Services
- Urban Native American Health Programs
- Youth Service Providers
- Other Health Service Agencies or Facilitators

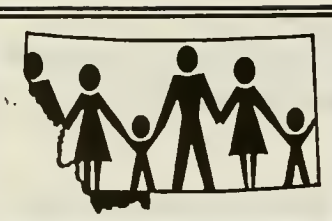
Local Community Leaders and Decision Makers

Other Government Agencies and Advisory Councils
- DPHHS and Advisory Councils and Other Divisions
- Other State Government Agencies and Councils
- Federal Government Agencies

Health Care Providers
- Health Centers and Clinics
- Child and Adult Day Care Homes and Centers
- Hospitals and Medical Assistance Facilities
- Private Practice Primary Care Providers
- Nursing Homes, Retirement Homes, Assisted Living Facilities, and Other Health Care Providers/Facilities

Health and Community Organizations
- National Public Health, Social Service, and Health Care Organizations
- Local Chapters of National Organizations, Church Organizations, and Citizen/Advocacy Groups
- Voluntary Health Organizations
- Charitable Programs and Privately Funded Foundations
- Statewide Health Service or Health Provider Organizations

Media--Newspapers, Radio and Television



OVERVIEW: TOWARD A HEALTHY MONTANA

DEVELOPING THE AGENDA:

The **Montana Health Agenda** is described by the DPHHS Health Policy and Services Division (HPSD) Administrator Nancy Ellery as, "our road map for the next 10 years."

The **Montana Health Agenda** began in HPSD as an effort to integrate the many program and strategic planning activities within the division. Developers in the Health Systems Bureau wanted a working document that would encompass statewide planning for community health needs, resources, and facilities; Medicaid and other health service programs; and state and local public health programs focused on specific areas of need (categorical programs). Rather than replacing all these planning efforts, the **Montana Health Agenda** was seen as an umbrella document that would bring them together into a single guide to strategic planning and policy.

HPSD staff reviewed other states' health planning reports, community and state government planning in Montana, and categorical program planning in DPHHS. Through the development process, the planning team grew from bureau- to division-level and encompassed in its review all state-level planning that had involved the division. Participants from throughout the state had contributed their time and ideas to program-, issue-, or organization-specific strategic plans. Drawing on those existing processes and plans, the HPSD planning team developed a list of their highest priority issues. A writing team made up of division staff was identified for each issue. Each team also drew heavily on the previous work of statewide partnerships, councils, and committees formed to address the issue. Each team identified a long-term goal and defined specific, measurable objectives to which HPSD program staff could commit. The first draft of the **Montana Health Agenda** was issued on January 15, 1998, and went through a statewide review. Authors incorporated that review and an intensive internal review of the January 15 draft into this document.

DEMOGRAPHIC PROFILE:

Montana is a rural state. While the majority of the population is in the mountainous, western half, Montana has more even distribution of population than most rural states. About 46% of the population live in counties with fewer than 50,000 residents. About 34% live in truly frontier counties averaging six or fewer persons per square mile.

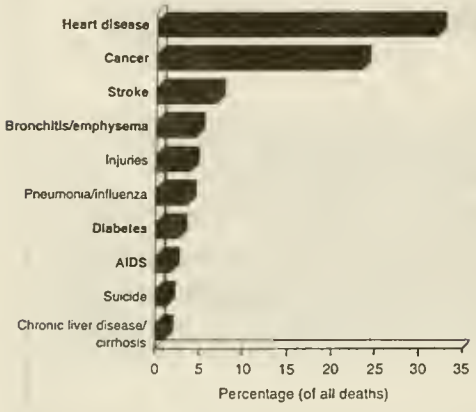
- The population is aging. The median age of Montanans was 27.1 years in 1970, 29.0 years in 1980, and 33.8 years in 1990.
- Montanans are generally employed, but not highly paid. Compared to the U.S. as a whole, a smaller proportion of residents are living in poverty. However, Montana's per capita income was about $4,300 per year below the national figure in 1995.

Almost 880,000 Montana residents are spread over 147,000 square miles–an average of just under six persons per square mile.

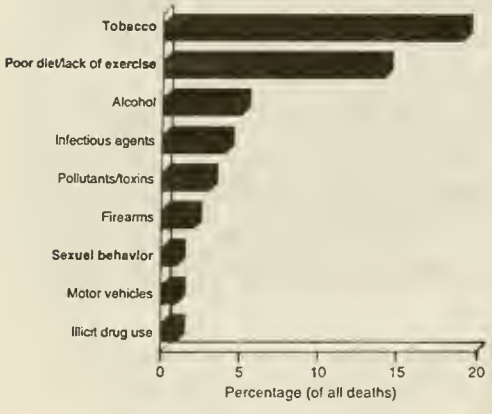
About 14% of Montanans had high out-of-pocket health costs in 1993, while 10% of the U.S. population were paying high out-of-pocket health costs.

Figure 1
Chronic Diseases
and Related Risk Factors

Leading Causes of Death
United States, 1995*



Actual Causes of Death
United States, 1990†



* Provisional data, National Center for Health Statistics, CDC, 1996.

† McGinnis JM, Foege WH, Actual Causes of Death in the United States, Journal of the American Medical Association, 1992, 270:2207-12.

- More than 80% of Montanans age 25 and older have at least a high school education. As of 1990, 33.5% of the population 25 and older had just a high school diploma and 47.5% also had college or university training.

- The vast majority of Montanans are White with the largest minority, Native American Indians, making up about 6% of the population. The remaining 1% of the population are Asians and Pacific Islanders (0.5%), Blacks (0.1%), and other races (0.5%). Persons of Hispanic origin constitute 1.5% of the population of Whites and non-Whites.

(Sources: Population distribution, age, education and ethnicity—U.S. Bureau of the Census; income and health care costs—State Profiles 1996, American Association of Retired Persons)

HEALTH CONDITIONS, INJURY, AND DISEASE IN MONTANA

Montanans tend to be healthier than the average U.S. resident, with some noteworthy differences. Compared to the United States as a whole:

- The risk of death from the leading causes, heart disease and cancer, is lower in Montana but far exceeds the risk of death from other causes.
- The risk of death from accidents, chronic obstructive pulmonary diseases (COPD), and suicide is greater.
- The infant death rate is lower, especially for Native Americans.
- Teens are less likely to be sexually active.
- Teens are more likely to use tobacco, especially smokeless tobacco.
- The immunization rate for two-year-olds improved 11% in one year.
- Gonorrhea rates have declined dramatically. However, rates for chlamydia have not declined in the past three years.
- The number of AIDS cases continues to increase, but not as rapidly as elsewhere in the U.S. for persons of all ages and lifestyles.

(Source: This and the following sections summarize the health of Montanans based on current vital statistics and health data. The tabulations and statistics on which these findings are based are available from DPHHS. Where the source of the data or analysis is not DPHHS, it is identified in the text.)

Health Risks for Montanans

Montanans need more information about their health risks so they can avoid unhealthy behaviors and conditions. The federal Centers for Disease Control and Prevention (CDC) funds the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS) to assess health risks from unhealthy or unsafe practices. National studies have shown clear relationships between the health risks addressed in these surveys and major health problems. An example is seat belt use and the severity of injuries from motor vehicle crashes. Tobacco use, poor diet, lack of exercise, and alcohol use are related to heart disease, cancer, respiratory illnesses, and diabetes. Poor pregnancy outcomes are related to gestational diabetes. Figure 1 shows the impact of unhealthy

habits and practices on mortality, comparing the 10 leading underlying causes of death—derived from medical information on the death certificate—with the "actual" causes of death associated with unhealthy or unsafe practices.

The most common health risk behavior among adults in Montana is sedentary lifestyle. About 50% to 55% of Montanans surveyed from 1992 to 1994 reported no regular exercise or physical activity; about 25% reported being overweight (1993 to 1995). Other prevalent risk factors were smoking, alcohol consumption, and poor diet. About 21% of Montanans reported regular smoking; 14% of those surveyed said they had five or more drinks on at least one occasion in the past month. Only 20% to 24% of Montanans report eating the recommended five or more servings of fruits and vegetables per day.

Montana youth smoke at about the same rate as youth throughout the U.S.—23% of YRBS respondents in 1993 and 1995. In 1997, 25% of Montana youth reported smoking regularly and 21% reported using smokeless tobacco in the 30 days prior to the survey. Nationwide, 11% of youth reported using smokeless tobacco in 1995. Figure 2 shows tobacco use among Montana and U.S. high school students surveyed in 1995.

Montana high-school students are slightly less sexually active than their national counterparts. In 1997 more than 60% of Montana's 12th grade students reported having had sexual intercourse. About 22% of 7th and 8th grade respondents in Montana reported having had sexual intercourse. Five percent of 7th and 8th graders and 16% of high-school respondents had had a total of four or more partners. About 45% of the teens with any sexual experience said they did **not** use a condom during the most recent sexual intercourse.

About 44% of Montana high school students said they had had five or more drinks within a few hours at least once in the prior month. Forty-five percent said they had tried marijuana, and 29% had used marijuana one or more times in the prior 30 days.

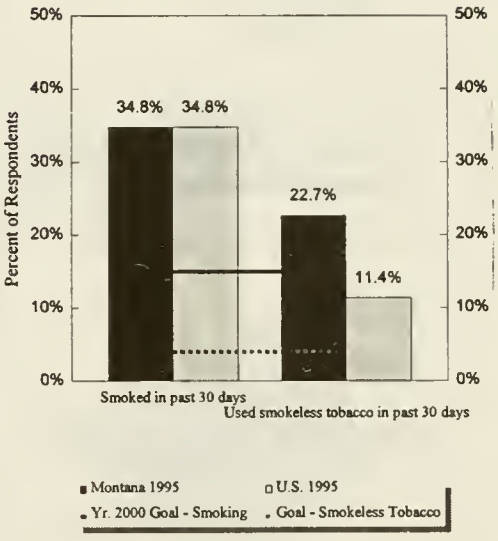
Safety risks include seatbelt use and driving after drinking alcohol. Thirty-two percent of high school respondents in 1997 and 23% of adults responding in 1995 said they rarely or never wore seatbelts. Teens were more likely to report drinking and driving than adults; in 1997, 27% of high school students reported drinking and driving within the past 30 days.

Maternal and Child Health

Montana's birth rate has been declining fairly steadily since the early 1980s.

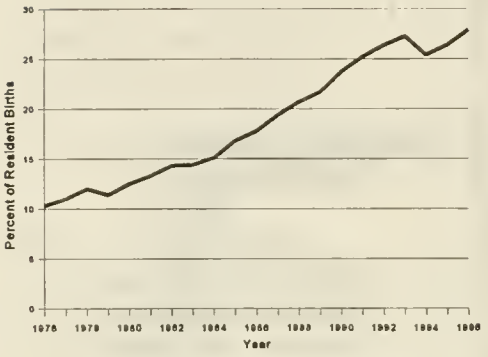
- There is a relatively high proportion of births to non-Whites. While 6% of the population is Native American, 10% to 12% of births are to Native American mothers.

Figure 2
Tobacco Use Among
Montana Adolescents
Percent Reporting Cigarette
and/or Smokeless Tobacco Use



(Source: Youth Risk Behavior Surveys, 1993 and 1995)

Figure 3
Births to Women
Who Were Not Married at
Any Time During the Pregnancy
Montana Residents, 1976-1996



- Montana's pregnancy rate for 15- to 17-year-olds was 41 per 1,000 females in 1994 to 1996. That rate is **below** both the national rate and the national year 2000 goal for that age group (50 per 1,000).

The proportion of births to women who were not married during the pregnancy has been growing since 1979 (Figure 3). These women are

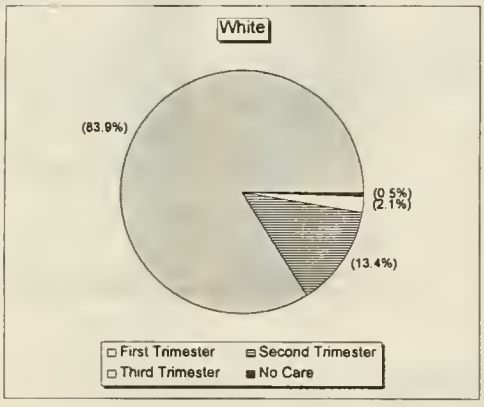
- Most likely to be 20 to 24 years old.
- Younger than their married counterparts–about nine years younger on average in 1989 to 1993. About one third of them are teen-aged (1989 to 1996), while 4% of those married are teens.
- Native Americans of all ages were much more likely to be unmarried during the pregnancy than women of any other race.

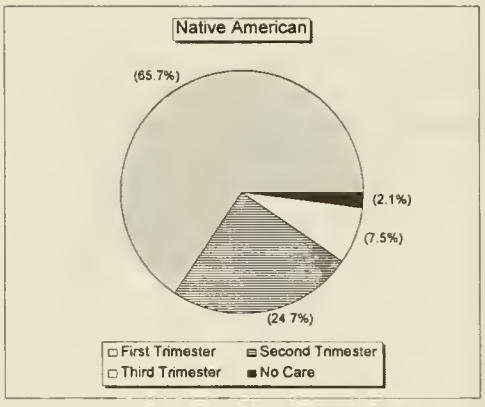
- Compared to White women in Montana, Native American women are more likely to become pregnant and give birth at a younger age. However, the age distribution of unmarried women giving birth in 1996 was about the same for all races.

The proportion of women receiving early prenatal care (beginning within the first three months of pregnancy) is increasing.

- About 22% of Montana resident women whose babies were born in 1989 received prenatal care after the first three months of pregnancy or received no care at all; 17% of women giving birth in 1996 received no or delayed prenatal care.
- Nationally and in Montana, White women are more likely to receive early care than non-White women. Figure 4 shows the timing of prenatal care by racial category, based on birth certificate data. It should be noted that Native American women receiving prenatal care through the Indian Health Service consistently receive earlier, more adequate care than non-White Montana residents in general.

Figure 4
Timing of Prenatal Care by Race
Montana Residents, 1994-1996





While the overall birth rate has been declining, the rate of low (less than 2,500 grams) and high (4,000 grams) birthweight births has changed very little between 1984 and 1996.

- Teenaged women tend to have lower birthweight babies than those aged 20 or older.
- Mothers who smoked or drank alcohol during the pregnancy tended to deliver lighter-weight babies.
- Native American women were more likely to have high birthweight infants than White women.
  - Native American women were more likely to have the pregnancy risk of diabetes, which was associated with the likelihood of having a high birthweight baby.
- Diabetes, as a pregnancy risk factor, is also associated in Montana with pre-term birth (less than 36 weeks gestation).

Montana has been successful in reducing infant mortality, achieving the year 2000 objective of 7 infant deaths per 1,000 live births in 1996.

- Infant death rates have gone down for newborns of all races.
- The Montana infant mortality for Native Americans has declined from more than double the national year 2000 objective for all races to below it.

- Sudden Infant Death Syndrome (SIDS) death rates are higher than for the U.S., but they have been declining.
- The death rate for infants between 28 days and one year of age remains higher than the year 2000 objective.

There are relatively few deaths of children age one to 17 in Montana. The leading causes of death of children are accidents, conditions related to the pregnancy or the birth process, cancer, and, for children more than 14, suicide. Boys are more likely than girls, and non-Whites are more likely than Whites, to die of unintentional injuries (accidents), particularly motor vehicle crashes. Very little else is known about the health status of Montana's children. An estimated 27,000 children in Montana are without health insurance or a health care coverage plan.

Chronic Diseases

Five of the eight leading causes of death in Montana are chronic diseases (Figure 5). Chronic diseases leading to deaths of those younger than 65 are, in this order, cancer, heart disease, cerebrovascular disease, chronic liver disease and cirrhosis, diabetes, and COPD—asthma, bronchitis, and similar conditions.

- Men in Montana are likely to succumb to heart disease at an earlier age than women.
- Non-Whites are more likely than Whites to die of heart disease before age 75.
- Montanans younger than 65 are more likely to die of accidents, cancer, or suicide (in that order of likelihood) than of heart disease.
- In Montana, a person dying of cancer is likely to be younger than one dying of heart disease.
- Alzheimer's disease is now a leading cause of death in Montana, but not the U.S.

Figure 5 shows the age-adjusted death rates—representing the relative risk of death—for the leading causes of death in Montana and the U.S.

For breast, prostate, and colo-rectal cancer, early diagnosis greatly improves chances of survival.

- The five-year survival rate is more than 80% for breast and prostate cancer (Figure 6), and it improves to more than 90% if the diagnosis is at an early stage—before the cancer has spread to surrounding tissue or lymph nodes.
- For cancers of the trachea, bronchus, and lung, even early diagnosis does not improve chances of survival to 40%. Prevention—primarily by not using tobacco—is the best way to reduce the risk of respiratory cancer death.
- Cancer survival may be related to race in Montana, as it is in the U.S.
  - Non-White women are less likely to contract cancer than White women, but those who have cancer are more likely to die of it—and at an earlier age—than men or White women.

Figure 5
Leading Causes of Death
Montana and the U.S.
Age-Adjusted Death Rates, 1996

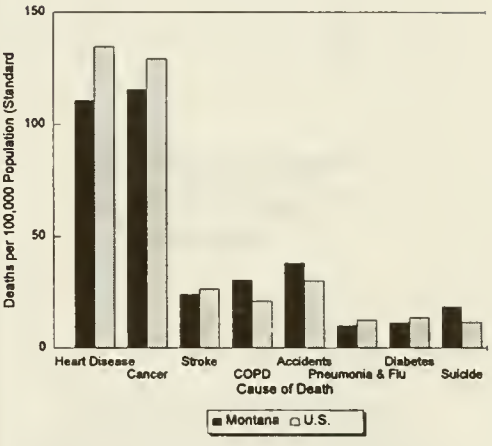
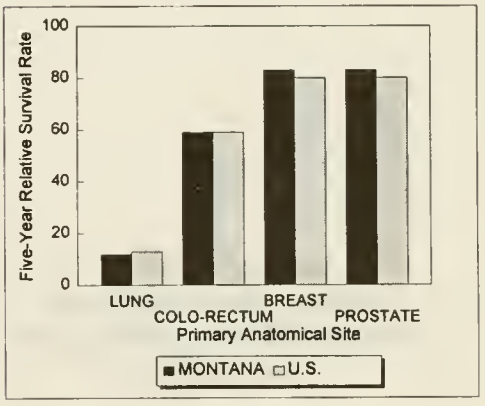


Figure 6
Cancer - Relative Survival Rates
Montana and the U.S., 1993



- The national pattern of non-Whites dying at an earlier age than Whites, and of males being more likely to succumb than females, holds for the three leading chronic disease causes of death–heart disease, cancer, and cerebrovascular disease–as well as for infant mortality and traumatic death.
- Diabetes is more likely to be a cause of death at any age for women than for men. Also, the relationship to race is clear: the death rates are higher for non-Whites than for Whites in every age group and overall.

Traumatic Injury and Death

Montana's suicide rates are among the highest in the nation.

- Suicides in the U.S. are most likely to be young, non-White males.
- In Montana, suicides are most likely to be male, but suicide is not solely a teen problem, nor is it more of a problem for non-Whites than for Whites.
  - Non-Whites who commit suicide are most likely to be young men, while Whites are likely to be men of any age above 14.
  - The persons most likely to commit suicide are men of any race aged 65 or older and non-White men 25 to 34.

The difference in motor vehicle crash death rates between the U.S. and Montana is even greater than the difference in suicide rates.

- In 1994, the accidental death rate (age-adjusted) was 34.6 for the U.S. and 45.7 for Montana.
  - Preventable, unintentional injuries, particularly motor vehicle crashes, are the major killer of young men in Montana. The accidental death rate for boys and men aged 15-34 was 83 to 86 deaths per 100,000 population, compared to rates of 43 for girls and women aged 15-24 and 22 for women 25-34 years.
  - For non-motor-vehicle accidents, those 75 years of age and older, especially men, are at greatest risk.
- The accidental death rate is about two and one half times higher for non-Whites aged 15-34 than for Whites in that age group. The difference is even greater for deaths from motor vehicle crashes.

Montana's homicide rates are much lower than national rates for both males and females. The non-White male has the greatest risk of being a homicide victim.

Communicable Diseases

Infectious diseases remain the leading worldwide cause of death and disability.

The spectrum of infectious diseases is expanding, and many infectious diseases once thought to be controlled are increasing. Microbes are among the most numerous and diverse of organisms on the planet, and pathogenic microbes can be resilient, dangerous foes. Although it is impossible to predict their individual emergence, new microbial diseases will certainly continue to surface.

Montana health departments conduct disease surveillance on about 60 diseases that impact the health of the general population. During a typical year, state and local health departments receive 700 to 1,000 reports, each

requiring follow-up and evaluation. With the exception of sexually transmitted diseases (STDs) discussed below, the most frequently reported illnesses in 1997 were Giardia (154 cases), Campylobacter (124 cases), Hepatitis A (71 cases), and other diseases causing gastrointestinal symptoms.

The majority of communicable diseases reported in Montana in 1997 were isolated and not the result of an outbreak in any specific area.

Less common conditions in 1997 included *escherichia coli* (*E. coli*) infections (42 cases), pertussis or whooping cough (19 cases), tuberculosis (17 cases) and one human rabies death.

Human rabies deaths are extremely rare in the United States, with four or five typically reported per year. Montana's 1997 case was the second ever reported in the state; the first was reported in 1996. The two rabies deaths were unrelated except in both cases the infection apparently resulted from contact with rabid bats.

Immunizations

Vaccines are highly cost-effective and are the most powerful tools to prevent infectious diseases such as measles, polio, and whooping cough. Key age groups for immunization are children from birth to two years and 11 to 12 years of age and adults at risk for influenza and/or pneumonia.

Widespread use of measles vaccine, particularly among children, has decreased Montana's annual reported cases from 137 cases in 1985 to 0 cases in 1997.

Vaccine-preventable disease incidence in Montana is very low because immunization coverage is at an all-time high. For the period between July 1996 and June 1997, the National Immunization Survey measured Montana's immunization rate for children aged 19 to 35 months at 78%. In contrast, the immunization rate for two-year-old children, determined by a retrospective survey, was estimated at 49% in 1990 and 52% in 1991.

The major focus in Montana and the U.S. has been on immunization for infants and toddlers, ensuring that all very young children are immunized. Adolescent and adult immunization programs are also important parts of preventing the spread of communicable diseases and are beginning to receive more special attention in Montana.

Sexually Transmitted Diseases (STDs)

The rate of STD infection is a reliable indicator of high-risk sexual behavior.

- In addition to potential negative long-term effects from the STDs themselves, groups with high STD rates are at risk for HIV infection.
- Increasing STD rates may provide an early warning of the heterosexual spread of HIV.
- Early detection is cost-effective in preventing epidemic spread of disease. The federal government spent $230 million on STD programs in 1995 (excluding HIV programs), while the direct cost of treating STDs was $7.5 billion. (Source: "The Hidden Epidemic," Institute of Medicine)

By the 12th grade, nearly 70% of American adolescents have had sexual intercourse.

Approximately one quarter of all students have had sex with four or more partners. (Source: "The Hidden Epidemic," Institute of Medicine, 1996)

The most commonly reported STDs in Montana are chlamydia, gonorrhea, and syphilis. Syphilis and gonorrhea rates in Montana are far

Figure 7
Montana Chlamydia Incidence
1991-1997

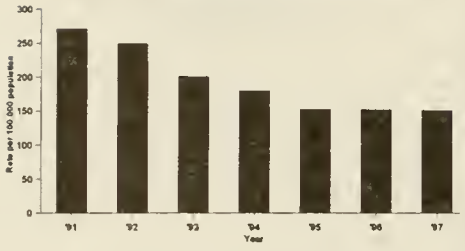


Figure 8
Montana AIDS Cases
Reported as of December 31, 1997

below the national averages. Since 1988, syphilis rates have remained constant in Montana, while gonorrhea rates have declined dramatically. Figure 7 shows chlamydia incidence rates in Montana by year from 1991 through 1997. At the beginning of this period, the rates were higher than the national rates; they are now lower. However, this trend has leveled off in the past three years.

HIV and AIDS

As of December 31, 1997, Montana has reported a total of 376 individuals diagnosed with AIDS as defined by CDC. Two-hundred and fifteen, or 57% of the cases reported, have died as a result of the illness. Forty-eight cases were reported during 1997. AIDS case reports do not reflect individuals infected with HIV who have yet to develop symptoms meeting the CDC case definition. DPHHS estimates as many as 500 Montanans may be infected with HIV. This number includes the reported 150 individuals whose HIV has progressed to the end-stage disease, AIDS.

- The incidence of AIDS is increasing in Montana (Figure 8). The sharp increase in case reports in 1993 resulted from a change in the case definition; it does not mark a change in the upward trend.
- The majority of cases (70% to 85%) reported well-established risk factors. Fifty-seven percent of reported AIDS cases were the result of homosexual contact, 11% were among injecting drug users, and 10% reported a combination of these factors.
- Unlike national trends, which are strongly influenced by large metropolitan areas, Montana has no indication of an increase in AIDS among heterosexuals. About 9% of currently reported AIDS patients were infected through heterosexual transmission.
- While perinatal transmission of HIV occurs in Montana, it is a rare event. Four neonatal AIDS cases were reported during an 11-year period (an average of one case every 2.7 years).

Emerging Diseases

Emerging infectious diseases that have recently affected the public health system include Legionnaire's disease, toxic shock syndrome, Lyme disease, AIDS, toxigenic *E. coli* enteritis, multi-drug-resistant tuberculosis, the Ebola virus, and rodent-borne hantavirus pulmonary syndrome. No matter how well-stocked our supply of drugs and vaccines, how well-planned our efforts to prevent and control epidemics, and how advanced our basic science and clinical understanding of infectious diseases, microbial diseases will continue to exist. Montana's public and private health professionals, including the public health laboratory, are and must remain trained and prepared to detect and control emerging diseases.

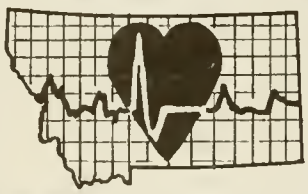
Environmental Health Conditions

The 1995 Montana Legislature implemented recommendations of the Governor's Task Force to Renew Government by transferring all programs

administered by the former Department of Health and Environmental Sciences into new Departments of Environmental Quality (DEQ) and Public Health and Human Services (DPHHS). The administrative separation of health and environmental programs does not diminish the important connection between Montanans' health and their environment. Preventing exposure to adverse physical, chemical, and biological elements in the environment remains a high priority on the state's environmental quality and public health agendas. Since environmental health efforts frequently cross jurisdictional boundaries, government agencies at all levels must coordinate health and environmental programs and work closely together to function most efficiently. DEQ/DPHHS interagency meetings are held quarterly to establish the close communication necessary to provide an environmental perspective to public health programs and a public health perspective to environmental programs. This multidisciplinary approach is intended to ensure all aspects of protecting health and the environment are considered in developing and carrying out the state's health and environmental policies.

Clean air, pure water, uncontaminated food, and other aspects of a healthy environment are vital conditions for healthy people.

PRIORITIES FOR HEALTHY MONTANANS



CARDIOVASCULAR DISEASE

MONTANA GOAL AND OBJECTIVES:

Reduce illness and death from cardiovascular disease.

- ❑ By January 1999, develop a cardiovascular disease (CVD) prevention and control plan.
- ❑ By December 31, 2000, begin achieving plan objectives to reduce major risk factors related to CVD: poor nutrition, sedentary lifestyle, tobacco use, obesity, hypertension, and high cholesterol.

WHY IT'S IMPORTANT:

- **Cardiovascular disease is the leading cause of death in Montana.** In 1996, cardiovascular disease caused almost 2,900 deaths—38% of the deaths of Montana residents. More than 400, or 23%, were less than 65 years of age.
- In 1994, the estimated direct and indirect cost of cardiovascular disease in Montana was about $500 for each man, woman, and child living in the state.
- **Cardiovascular disease impacts individuals of all ages.** Five percent of all heart attacks occur in people younger than 40.

Forty-five percent of all heart attacks occur before the 65th birthday.

- **The risk of cardiovascular disease can be reduced.**
  - Coronary heart disease and stroke are associated with diets high in fat, low in fiber, and low in fruits and vegetables. Yet only 24% of Montanans report eating at least five daily servings of vegetables and fruits. Just 10% have six or more daily servings of grain products.
  - In Montana, one out of every five deaths can be attributed to tobacco use. However, almost 21% of those aged 20 and older smoke. About 25% of Montana high school students are regular smokers.
  - Regular physical activity plays a role in the prevention and management of coronary heart disease and has been associated with lower rates of stroke. Only 24% of Montanans report engaging in 30 minutes of light to moderate physical activity at least five times per week.

Cardiovascular disease costs Montana *$421,000,000 annually.* (Source: State Cardiovascular Disease Highlights, CDC, 1997.)

- **Early detection of CVD can prolong and improve the quality of life.**

  Elevated blood cholesterol is a major risk factor for heart attack. The proportion of Montanans who have had their cholesterol levels checked is increasing, but in 1995, 30% of Montanans surveyed had never had it checked.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ The DPHHS Chronic Disease Prevention and Health Promotion Section's nutrition, physical activity, and tobacco prevention and control programs address health risks that are the actual causes of CVD.
- ✔ In December 1997, representatives from CDC met with Chronic Disease Prevention and Health Promotion staff to begin planning for a coordinated program of CVD-related education and disease prevention activities.
- ✔ ***5 a Day*** education informs Montanans about the importance of eating five servings of fruits and vegetables each day. Projects in two settings—Head Start and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)—yielded significant increases in fruit and vegetable intake. In September 1997, Buttrey stores statewide held a promotion of **National *5 a Day* Week**.
- ✔ ***Move Across Montana*** involves people in healthy lifestyles by making a friendly competition of tracking and improving their physical activity and dietary practices. DPHHS' Health Policy and Services Division employees piloted this program. A similar program is being piloted for elementary-school-age children as **Take Responsibility for Yourself (TRY)** in the spring of 1998. Children will track their physical activity levels and health and safety activities as "miles" traveled across a map of Montana, with bonus miles for family involvement and participation.
- ✔ ***Young Adults Helping Others Understand (Y.A.H.O.U.)*** supports projects planned and coordinated by students that focus on tobacco use prevention. So far, six youth groups have each received a $500 project award and structured training.

WHAT STILL NEEDS TO BE DONE:

- ❑ Document needs, form a broad-based planning group, and develop and evaluate pilot projects to reduce the burden of CVD in Montana.
- ❑ Coordinate these pilot projects and ongoing categorically funded programs.
- ❑ Develop and disseminate information about the burden of CVD and associated risk factors in Montana.
- ❑ Seek funding for coordinated CVD program development that includes the pilot projects.

WHERE IT NEEDS TO BE DONE:

Settings in which these CVD prevention and control activities can be implemented include: public and private health systems; work sites; schools--preschool through college; local, state, and federal health agencies; and media. Each of these areas should be represented in the CVD program planning group. The pilot CVD projects should encompass public and private health systems, community-based activities, and health communications.

FOR MORE INFORMATION, CONTACT:

CVD Program
(406) 444-2672

CANCER

MONTANA GOAL AND OBJECTIVES:

Promote prevention and early detection of cancer.

- ❑ Create an integrated and coordinated cancer prevention and control program within DPHHS.
  - ■ Develop a priority listing of the cancers impacting Montanans and the associated risks by December 31, 1998.
  - ■ Work with the Montana Central Tumor Registry to enhance Montana's cancer surveillance system and facilitate program planning and evaluation.
    - ■ Establish an ongoing program of assessment to define and measure progress toward Montana's cancer prevention and control goals by December 31, 1998.
    - ■ Update the Cancer Fact Book, Part I of The Impact of Cancer on Montana by June 30, 1999, and publish Part III, Technical Appendix by December 31, 1999.
- ❑ Increase the capacity, quality, and accessibility of cancer prevention and control services to reduce the levels of avoidable cancer risks for Montana's citizens.
  - ■ Provide ongoing, comprehensive breast and cervical cancer screening, education, and diagnostic services to eligible women through the Breast and Cervical Health Program (BCHP). Expand early detection, screening, and public education statewide by December 31, 2000.
  - ■ By December 31, 1999, expand the statewide tobacco prevention and control program and continue the focus on youth, including Native American youth, and women of childbearing age.

Cancers of the mouth, throat, and respiratory system account for almost 20% of cancers in Montana.

In 1997, 25% of Montana high school students reported they smoked regularly, and 33% of males in grades 9 through 12 reported using smokeless tobacco regularly.

(Source: Montana YRBS, 1997)

WHY IT'S IMPORTANT:

- Tobacco use, poor diet, lack of exercise and other unhealthy behaviors are associated with many cancers.
  - Smoking causes 87% of lung cancers nationwide, and fewer than 50% of those diagnosed will survive at least five years.
  - The use of smokeless tobacco greatly increases risk of cancer of the oral cavity and pharynx.
  - A National Cancer Institute report associates 35% of all cancer deaths with diets high in fat and calories and low in fiber, fruits, and vegetables.
- Almost half of cancers diagnosed in Montana are breast, prostate, and lung cancers.
- Early detection of breast and prostate cancer increases 5-year survival rates.
- Programs that reduce tobacco use, provide early detection screening, and promote proper nutrition, increased physical activity, and a healthy lifestyle can prevent cancer or reduce the incidence of—and deaths associated with—many cancers.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ The Montana Legislature passed the Youth Access to Tobacco Products Control Act in 1993 and the Minor-in-Possession Act in 1995.
- ✔ DPHHS' cancer registry is in the third year of an enhancement project to improve our understanding of the impact of cancer on Montana.
- ✔ In 1995, DPHHS published The Impact of Cancer on Montana, Part I: Cancer Fact Book and Part II: Strategic Plan, A Five-Year Focus on Montana, 1995-1999.
- ✔ The *5 a Day* project provides education about the importance of eating five servings of fruits and vegetables each day.
- ✔ In 1997, DPHHS' BCHP moved from a planning grant to funding of six comprehensive, local breast and cervical cancer screening programs. The program continues to develop and expand its statewide screening and education components, while evaluating and assuring the quality of clinical services.
- ✔ Montana's attorney general filed a lawsuit against tobacco companies to recoup Medicaid monies spent to treat tobacco-related diseases and stop deceptive trade practices in the use of advertising that appeals to children.
- ✔ The Montana Tobacco Prevention and Control Program funds and collaborates with statewide and community-based Tobacco-Free Montana coalitions to carry out tobacco prevention activities. In addition, the program provides tobacco prevention education and training and conducts education and media advocacy campaigns. These are aimed at reducing youth access to tobacco, increasing awareness of the public health benefits of increasing the cost of tobacco products, increasing awareness of the health effects of environmental tobacco smoke, and emphasizing the need for clean indoor air policies. The program works to ensure compliance with laws restricting tobacco sales to minors.

WHAT STILL NEEDS TO BE DONE:

Use the cancer priority list and associated risks identified to further develop and implement a comprehensive plan to reduce the impact of cancer.

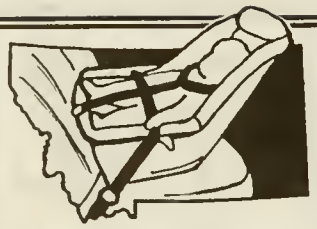
- ❑ Continue to promote and expand the Breast and Cervical Health Program.
- ❑ Continue to implement tobacco prevention and control activities, especially those addressing youth tobacco use.
- ❑ Educate the public and policy makers about the health benefits of strong policies concerning tobacco use.
- ❑ Participate in allocation of potential tobacco settlement monies, ensuring that funds are directed toward tobacco prevention and control programs.
- ❑ Request authorization from the Montana Legislature to use tobacco settlement funds and additional grant funds from CDC for continued and expanded tobacco prevention and control activities.

WHERE IT NEEDS TO BE DONE:

The Health Systems Bureau will facilitate the coordination of planning for cancer prevention and control. Other state agencies, local health departments, treatment facilities, private providers, community coalitions, and other organizations throughout Montana will continue to be involved in moving this plan forward.

FOR MORE INFORMATION, CONTACT:

Chronic Disease Prevention and Health Promotion Section
(406) 444-2640
Montana Breast and Cervical Health Program
(406) 444-5442
Montana Tobacco Prevention and Control Program
(406) 444-2640

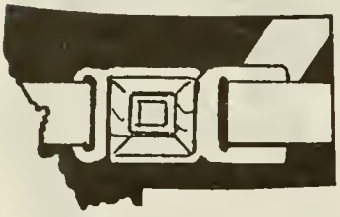


UNINTENTIONAL INJURY

MONTANA GOAL AND OBJECTIVES:

Bring about long-term reductions in unintentional injury by establishing the Injury Prevention and Control Program as a permanently funded program within DPHHS.

- ❑ Reduce unintentional injury by 5% by January 1, 1999.
- ❑ Reduce fall injury by 5% by January 1, 1999.
- ❑ Decrease unintended injury, especially injury involving motor vehicle crashes:
  - Increase the average seat belt use rate among all drivers to 85% by December 31, 2000, and to 90% by 2005.
  - Reduce child occupant fatalities (0-4 years) by 15% by December 31, 2000, and by 25% by 2005.



Injury is the leading cause of death of Montanans from ages 1 through 44.

Motor vehicle crashes are the leading cause of injury and death in Montanans aged 1 through 44 years.

WHY IT'S IMPORTANT:

- In the past decade, more than 6,000 people have died from unintended injuries in Montana.
- A ***portion*** of the data representing serious trauma and hospitalizations (from the System Trauma Register representing two-thirds of Montana hospitals) shows Montana's leading injury areas are motor vehicle crashes, falls, firearm related injury, and drowning:
  - From 1991 through 1996, 1,968 Montana citizens and visitors were hospitalized from fall injuries.
  - In the same time period, 763 persons were hospitalized with firearm injuries.
- Improperly belted or unbelted vehicle occupants accounted for 71% of traffic deaths in 1996.
  - The driver of a vehicle involved in a crash in Montana is 12 times more likely to die if not wearing a seatbelt than if wearing a seatbelt.
  - In 1996, six children less than four years old died in motor vehicle crashes. Although 75-80% of Montana parents use child safety seats, correct use is 10% or less. Properly used child safety seats are 75% effective in reducing serious trauma and fatalities.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ DPHHS has established an **Injury Prevention and Control Program** and hired a statewide **Injury Prevention Coordinator**.
- ✔ The Injury Prevention and Control Program is funded by a grant from the Emergency Medical Services for Children program and is being implemented as part of the State Trauma Care System.
- ✔ A statewide injury prevention and control plan is near completion.
- ✔ The program is co-coordinating the **Child Occupant Protection Program** with the Montana Department of Transportation's Highway Traffic Safety Bureau.
- ✔ The program coordinated a successful **Open Water Drowning** prevention campaign in 1997.
- ✔ The program has been coordinating **local injury prevention awareness and activities** through the **Regional Trauma Advisory Committees**.

WHAT STILL NEEDS TO BE DONE:

- ❑ The Injury Prevention and Control Program should secure permanent funding as an integral component of the State Emergency Medical Services (EMS) and Trauma System.
- ❑ The Injury Prevention and Control Program will use Trauma Registry and other data to identify target areas of injury prevention need and then evaluate the effectiveness of its efforts.
- ❑ The active involvement of emergency medical services, health care providers, public safety personnel, and other community-based organizations will be encouraged through the provision of training, technical assistance and evaluation. The Injury Prevention and Control Program will work with Regional Trauma Advisory Committees and EMS providers to facilitate the use of a wide arsenal of proven techniques to prevent injury in Montana including education, suggested legislation, and changed safety designs.

WHERE IT NEEDS TO BE DONE:

The Injury Prevention and Control Program must operate statewide. The state-level program will assist in targeting and coordinating the efforts of many different organizations and coalitions, relying on the input and participation of the Regional Trauma Advisory Committees, local emergency medical services, health care providers, public safety personnel, and others.

FOR MORE INFORMATION, CONTACT:

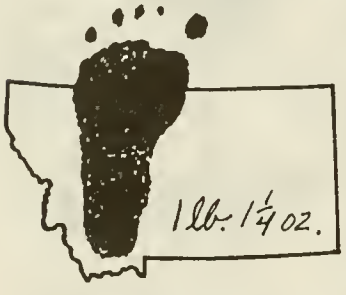
Thom Danenhower
Injury Prevention Coordinator
(406) 444-4126
E-mail:
tdanenhower@mt.gov

PREGNANCY OUTCOMES

MONTANA GOAL AND OBJECTIVES:

Improve pregnancy outcomes.

- ❑ By December 31, 1999, increase to 90% the proportion of pregnant women who enter prenatal care within the first 12 weeks of pregnancy and who have an adequate number of prenatal visits.
- ❑ Reduce fetal-infant mortality to 11.5 per 1,000 live births and fetal deaths by December 31, 2000.
- ❑ Develop further baseline information on mothers and infants in Montana by December 2001
  - Determine how many women in Montana die within 12 months of giving birth.
  - Assess the relationships among maternal risks, unhealthy birthweights—both very high and very low birthweight— and unhealthy birth outcomes for mother and infant.
  - Develop reliable measures of health risks to pregnant women:
    - Smoking prior to and during their pregnancies.
    - Alcohol consumption during their pregnancies.



The financial impact of poor pregnancy outcomes is enormous. One day in a Montana neonatal intensive care unit costs $1,500-$2,000.

A high-risk newborn can spend the first several months of life in an intensive care unit at a cost of $45,000 to $60,000 per month.

WHY IT'S IMPORTANT:

- The consequences of a poor pregnancy outcome are profound and life-threatening. Poor pregnancy outcomes such as prematurity and low birth-weight can result in
  - Death of the infant and/or the mother.
  - Long-term—perhaps lifelong—health problems including blindness, cerebral palsy, deafness, developmental delays, and other conditions affecting mobility or development.
  - Emotional and financial impact on the child, the family, and society as a whole.
- Risks for poor pregnancy outcomes include:
  - Inadequate prenatal care
  - Poor nutrition
  - Homelessness and poverty
  - Physical and emotional abuse
  - Tobacco, alcohol, or other harmful substance use
  - Unintended pregnancy
  - Maternal age (too young or too old)
  - Untreated underlying medical conditions
  - Inadequate spacing of pregnancies

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ Montana's Initiative for the Abatement of Mortality in Infants (**MIAMI**) has 31 projects throughout Montana providing services for more than 80% of our pregnant population. Three sites on Indian reservations are being added in 1998. Most counties in Montana employ public health nurses to provide services to pregnant women and their infants, even if the county has no MIAMI project.
- ✔ MIAMI targets pregnant women who are at highest risk for poor pregnancy outcomes. In 1996, the rate of low birthweight births (less than 2,500 grams) was about six in every 1,000 live births.
- ✔ Montana's fetal-infant mortality rate from 1994 to 1996 was 12.4 per 1,000 live births and fetal deaths.
- ✔ MIAMI helps pregnant women at economic risk with access to health care through mechanisms such as Medicaid presumptive eligibility. In 1996, 82% of pregnant women in Montana began prenatal care in the first 12 weeks of pregnancy; 72% received an adequate number of prenatal visits between their entry into care and the delivery of their infants.
- ✔ The 1997 Legislature authorized local and state **F**etal/**I**nfant/**C**hild **M**ortality **R**eview (FICMR) teams with the goal of preventing fetal, infant, and child deaths. The Community Health Section of HPSD's Family and Community Health Bureau and local health department staff coordinate the development of the FICMR process. Local FICMR teams are being formed throughout the state.
- ✔ Statewide public education campaigns have encouraged pregnant women to seek early prenatal care and to stop or decrease use of tobacco, drugs, and alcohol. DPHHS staff also provide public education about pregnancy, risk reduction, the importance of good health care during pregnancy, community services available to pregnant women, and health and safety risks to infants.

WHAT STILL NEEDS TO BE DONE:

- ❑ Expand MIAMI services to include urban Native American women and other high-risk pregnant women while continuing to support MIAMI initiatives to:
  - Improve access to quality medical care for pregnant women
  - Develop and distribute public education materials
  - Assist local projects in securing other third-party payment for services
- ❑ Expand family planning services to low- and marginal-income women in underserved areas of the state.
- ❑ Promote hearing screening for all newborns so appropriate and timely interventions can occur.
- ❑ Start a birth defects monitoring program to help understand why 8% of Montana's infants are born with one or more abnormalities or potentially serious problems.
- ❑ Expand the local network of FICMR teams and convene the state review team regularly.

WHERE IT NEEDS TO BE DONE:

- ❑ MIAMI needs to make its locally provided services available to 100% of Montana's pregnant women.
- ❑ DPHHS needs to coordinate hearing screening and monitoring of birth defects at the state level.
- ❑ Local FICMR teams need to work with local public health departments and other services to reduce fetal, infant and child mortality.

FOR MORE INFORMATION, CONTACT:

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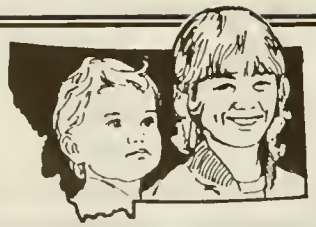
(406) 444-2574
E-mail: spettit@mt.gov



CHILD AND ADOLESCENT HEALTH

MONTANA GOAL AND OBJECTIVES:

Ensure that Montana's children will have the opportunity to grow up healthy and strong.

- ❑ Assure that at least 90% of children and adolescents have access to a primary care provider and health insurance or coverage by a health care plan, by December 31, 2000.
- ❑ Establish 10 regional centers for childhood lead screening by January 31, 1999.
- ❑ Support youth education and peer programs about use of alcohol, tobacco, and other drugs. Restrict tobacco advertisements appealing to children and fund a counter advertising campaign by June 30, 2001.
- ❑ Promote the best nutrition for children by increasing referral to and enrollment in the WIC program by 3% by December 31, 2001.
- ❑ By the year 2010, reduce by 30% the number of out-of-home foster placements.

Adequate health care for children results in a healthy start, promotes resiliency, and assures a positive self-image.

WHY IT'S IMPORTANT:

- A safe, healthy start for Montana's children can ultimately reduce costs of drug and alcohol treatment, juvenile justice, remedial education, foster care, and adult incarceration.
- The cost of prevention, early detection, and treatment of illness is less than treatment for end stage disease. While medical treatment can prevent 10% of early deaths, public health and prevention can prevent 70% of early deaths. (Source: U. S. Department of Health and Human Services)
- Violent behavior by and toward youth is not acceptable. Its effect on youth is devastating and causes lifetime damage.
- Good nutrition, a positive self-image, and a safe environment enable a child to learn, to be a productive, contributing member of society, and to enjoy life to the fullest.
- While the risk of communicable disease has decreased, Montana children and youth face other health risks—including violence, suicide, and unintentional injury. Addressing these problems requires approaches that are culturally sensitive and draw on many areas of expertise.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ Governor Marc Racicot established a **Council on Children and Families** in June 1996.
- ✔ The Office of Public Instruction (OPI) developed the Montana Behavior Initiative to improve the capacity of schools and communities to meet the diverse and complex needs of children. The approach is **to develop refusal, conflict resolution, and other coping skills in children and adolescents.**
- ✔ HPSD is participating with DPHHS' Prevention Resource Center and Addictive and Mental Disorders Division in a multi-agency project to identify and assess youth risk and protective factors.
- ✔ To assist Montanans in getting a healthier start in life, DPHHS has submitted a plan to take advantage of the Children's Health Insurance Plan (CHIP). **CHIP will enhance access to health care for most children in Montana's low-income working families** who have previously been uninsured.
- ✔ The Medicaid **Passport to Health** Program assures access to basic health care for **32,000 children.**
- ✔ Statewide, **WIC provides nutrition screening, education, and diet supplements** for families at nutritional risk who are at or below 185% of the federal poverty level.
- ✔ **Parenting and nutrition education** components are included in many **FAIM** contracts.
- ✔ **Special Health Services** (SHS) promotes healthy outcomes using a **family-centered, community-based** system of care so children with disabilities can lead a productive life.
- ✔ DPHHS provides training to local WIC staff and to food program staff at child and adult care homes promoting healthy relationships between children and parents regarding eating and nutrition.

WHAT STILL NEEDS TO BE DONE:

- ❑ Ensure all youth have a continuous source of basic health care by:
  - Implementing CHIP to ensure access to adequate health insurance.
  - Coordinating CHIP, Maternal & Child Health, Medicaid, and the Mental Health Access Plan and promoting Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Passport to Health Programs statewide.
- ❑ Expand child immunization surveillance to include preteens.
- ❑ Support the Montana Behavior Initiative's model for technical assistance for local staff.
- ❑ Collaborate with school- and community-based programs to prevent youth tobacco use.
- ❑ Expand the lead surveillance program to screen children age two and younger.
- ❑ Support expansion of school nutrition programs.
- ❑ Increase mental health referrals for youth with multiple juvenile justice encounters.
- ❑ Collaborate with private professionals and paraprofessionals to develop standards for FAIM nutrition and parenting education components.
- ❑ Develop a family-centered service delivery method through the SHS parent coordinator.

WHERE IT NEEDS TO BE DONE:

These goals can be accomplished only by involving Montanans at the community level, with DPHHS providing funding, training, and technical assistance. DPHHS will ask the 1999 Legislature for a general fund appropriation for CHIP. Approval will allow Montana to receive about $10 million per year in federal funds. These funds will be used to insure children of low-income working families. CHIP will be administered at the state level by DPHHS. A broad-based advisory council will continue to assist DPHHS with the oversight of CHIP.

FOR MORE INFORMATION, CONTACT:
Child and Adolescent Health Section
(406) 444-3622
Nutrition Section (WIC)
1-800-443-4298

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Immunization Program
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Judy Garrity
Prevention Resource Ctr.
(406) 444-5986

CHIP
Medicaid Services
Bureau Chief
(406) 444-4144
E-mail: mdalton@mt.gov

UNINTENDED PREGNANCIES

MONTANA GOAL AND OBJECTIVES:

Decrease unintended pregnancies.

- ❑ Promote the concept that all pregnancies should be intended—that is, consciously and clearly desired at the time of conception.
- ❑ Develop baseline data to determine baseline rates for unintended pregnancy for all women and for teens and for the average cost to the state for each unintended pregnancy by December 31, 1998.
- ❑ Establish an unintended pregnancy benchmark and a plan for achieving it by December 31, 1999.
- ❑ Select two or three communities and develop pilot unintended pregnancy programs targeted to populations with high rates of unintended first or repeat pregnancies by December 31, 2001.
- ❑ Develop an abstinence education training manual and involve parents, families and local communities in the Assets for Abstinence program by December 31, 1998.

Nationally, 62% of all pregnancies are unintended.

About 40% of pregnancies among married women are unintended, as are

- 50% of pregnancies among women aged 20 to 34.
- More than 75% of pregnancies among women older than 40
- 82% of pregnancies among teens

(Source: National Institute of Medicine)

WHY IT'S IMPORTANT:

- An unintended pregnancy is one that
  - is wanted, but later—it occurs sooner than desired

  OR
  - is unwanted—it is not wanted at any time.

- **Babies resulting from unintended pregnancies are more likely to:**
  - Have a low birthweight.
  - Suffer abuse.
  - Die in their first year.
  - Be exposed during gestation to harmful substances such as tobacco and alcohol.
- **Mothers of these babies:**
  - Are less likely to seek early prenatal care.
  - Are more likely to suffer abuse, depression, and economic hardship.
  - Are more likely to have insufficient family resources for a child's healthy development.

  (Source: National Institute of Medicine)

- In Montana, the majority of women who were not married at any time during the pregnancy are 20 years of age and older.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ The DPHHS Women's Health Section helped prevent an estimated 19,050 unintended pregnancies in 1995 through Title X family planning services in communities throughout Montana.
- ✔ Governor Racicot and DPHHS established the **Teen Pregnancy Issue Focus Team** in December 1996 **to develop a strategic plan for unintended pregnancies in Montana**. The Teen Pregnancy Issue Focus Team identified seven action areas: state, local community, health care provider, marketing/ message, family, school, and teen. For each action area, the team developed strategies for reducing unintended pregnancies and generated ideas for an action plan. This plan is designed to help local communities develop and adopt programs to lower unintended and teen pregnancy rates.
- ✔ In 1997, the federal Maternal and Child Health Bureau (MCHB) awarded Montana a grant to provide abstinence-only pregnancy prevention education to parents and youth. The governor appointed a statewide coalition representing a broad-based constituency to oversee this grant.
- ✔ The "Don't Kid Yourself" campaign was implemented in 1997 in 14 Montana communities targeting young women and men aged 18 to 24 to reduce the number of unintended pregnancies among young adults. The "Don't Kid Yourself" campaign involves radio spots, ads in local and college newspapers, posters, and drinking coasters for local bars and clubs. The message includes birth control options and the availability of family planning clinic services.

WHAT STILL NEEDS TO BE DONE:

- ❑ Hold a Governor's conference on Unintended Pregnancy in 1998.
- ❑ Continue and expand on the work of the Teen Pregnancy Issue Focus Team.
  - Plan and implement abstinence education programs throughout the state.
  - Expand the "Don't Kid Yourself" campaign to reach young adults throughout Montana.
- ❑ Develop peer education and male accountability components of the Assets for Abstinence program. Reach at least 6 new communities per year with the abstinence education training program.
- ❑ Continue developing information systems and methodologies to provide data on unintended pregnancies in Montana so that efforts can be directed at the right age-groups in a culturally sensitive way.
- ❑ Apply to the Health Care Financing Administration (HCFA) for a waiver to expand Medicaid eligibility for family planning services.
- ❑ Expand family planning services to low- and marginal-income women in underserved areas of the state.
- ❑ Establish family planning training in public assistance settings.

WHERE IT NEEDS TO BE DONE:

Settings in which these activities will be accomplished include: local communities, middle schools, high schools, colleges and universities; churches; family planning and community health clinics; local, state, and federal public health and public assistance agencies; and the print and broadcast media.

FOR MORE INFORMATION, CONTACT:

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Women's Health Section
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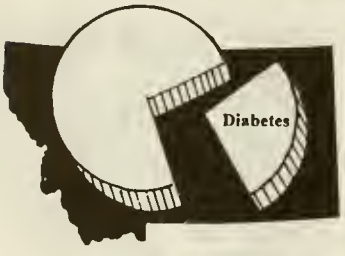
MONTANA DIABETES PROJECT

DIABETES

MONTANA GOAL AND OBJECTIVES:

Reduce the burden of diabetes and its complications.

- ❑ The burden of diabetes can be measured in terms of death, disability, health care utilization, and expenditures. CDC has provided funding through June 30, 1999, to work on three objectives:
  - Define, monitor, and disseminate information about the burden of diabetes in Montana.
  - Develop, implement and evaluate new approaches to reduce the burden of diabetes and its complications in Montana, including health systems approaches, community-based approaches, and health communication efforts.
  - Coordinate existing resources to reduce the burden of diabetes in Montana through collaborative programs and maintenance of Montana Diabetes Project Advisory Coalition.



U.S. Medicare Budget

An estimated 53,000 Montanans—6% of the population—have diabetes. About half of that number—3%—have been diagnosed.

In 1997, about 14% of Native Americans surveyed reported having diabetes.

WHY IT'S IMPORTANT:

- The incidence and prevalence of diabetes are increasing.
- Diabetes contributes to the death of 500 Montanans per year. As a leading cause of death, it ranks seventh for all Montanans, and fourth for Native American Montanans.
- Annually there are an estimated 7,504 hospitalizations related to diabetes, and 2,300 of these are cardiovascular-associated hospitalizations.
- The burden of diabetes associated with health care costs is extremely high. In Montana, approximately $13,000 is spent each year in direct and indirect costs per person with diagnosed diabetes. Nationally, more than one-fourth of the Medicare budget is spent on diabetes-related care. (Source: "The Economic Bottom Line of Preventive Diabetes Care," Claresa Levetan, MD, and Robert Ratner, MD; **Practical Diabetology**, December 1995.)
- The burden associated with the severe complications of diabetes in Montana is high. Every year we have about 40 new cases of blindness, 150 lower extremity amputations, and 60 to 65 new cases of end-stage renal disease. Most of these complications could be prevented.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ The Montana Diabetes Project (MDP) received initial funding from the CDC in 1995. A Statewide diabetes control plan was developed in 1996 by a broad-based coalition of Montana providers, professionals, and persons with diabetes to direct the activities of the MDP.
- ✔ In collaboration with the Mountain-Pacific Quality Health Foundation (MPQHF) the MDP is developing a diabetes surveillance system to assess the scope of diabetes in Montana.
- ✔ The MDP is working with MPQHF to describe health care utilization among Medicare beneficiaries with diabetes.
- ✔ The MDP and the MPQHF have developed a diabetes care quality improvement program that is being implemented in primary care practices in Montana.
- ✔ The MDP and MPQHF have completed direct mailings to Medicare beneficiaries with diabetes encouraging annual eye examinations and regular moderate physical activity.
- ✔ The MDP is implementing the Quality Diabetes Education Initiative—a statewide program to increase the number of persons and programs providing diabetes education.
- ✔ The MDP is working collaboratively with Native Americans on the Northern Cheyenne Reservation and in Missoula to develop culturally sensitive, community-based diabetes programs.
- ✔ The MDP co-sponsors an annual statewide patient/professional diabetes education conference.
- ✔ The MDP maintains an active diabetes advisory coalition that meets quarterly.

WHAT STILL NEEDS TO BE DONE:

- ❑ Expand quality improvement programs targeted toward Montana health care professionals to prevent or reduce the complications associated with diabetes.
- ❑ Expand intervention programs targeted toward Montanans with diabetes to reduce the associated complications.
- ❑ Increase awareness of the seriousness of diabetes and importance of screening for diabetes among Montanans at risk.
- ❑ The MDP is applying for comprehensive funding (FY 1999) from the CDC and will seek legislative approval to use these funds.

WHERE IT NEEDS TO BE DONE:

The MDP and its partners are taking the lead—working with health systems such as Medicare, Medicaid and managed care organizations—to accomplish Montana's goal and objectives in a variety of settings:

- ❑ Community senior centers, hospitals, private clinics, and community health centers.
- ❑ State professional associations.
- ❑ Media—public information programs.

FOR MORE INFORMATION, CONTACT:

Montana Diabetes Project Coordinator
(406) 444-0593

SEXUALLY TRANSMITTED DISEASES

MONTANA GOAL AND OBJECTIVES:

Reduce the incidence of sexually transmitted diseases in Montana, particularly in our adolescent and young adult population.

- ❑ Keep the rate of chlamydia at or below 150 per 100,000 persons in the Montana population through 1998 and reduce it to 100 per 100,000 population or less by January 1, 2005. Reduce the rate of chlamydia among Native Americans to 600 per 100,000 population by January 1, 2005.
- ❑ Reduce the number of sexually active adolescents to 40% by January 1, 2005.
- ❑ Of those youths who are sexually active, increase the percentage who consistently use condoms from 55% to 60% and reduce the number infected with chlamydia to 400 by January 1, 2005.

In 1997, 46% of Montana adolescents surveyed reported that they were sexually active; only 55% of those sexually active adolescents reported using condoms.

In 1996, approximately 1,200 cases of chlamydia were reported in Montana; 500 (46%) of those cases occurred in 15-19 year olds.

WHY IT'S IMPORTANT:

- Sexually transmitted diseases (STDs) are the most commonly reported infectious diseases in Montana. Continued education, screening, and treatment have virtually eliminated syphilis and gonorrhea in Montana, but chlamydia is still prevalent.
- Untreated, chlamydia can lead to inflammation of reproductive organs. Ultimately women may develop pelvic inflammatory disease (PID)—a very serious infection of all reproductive organs. PID is difficult to treat, often requires expensive hospitalization, and frequently results in infertility.
    - It costs an estimated $7,500 to $15,000 to treat a single case of PID disease–not including costs associated with infertility or tubal pregnancy, which can result from the scarring created by the pelvic inflammation. A test for chlamydia costs $12.20.
    - Based on estimates from a universal screening project conducted in Montana in 1997, routinely screening all women under 25 years of age would increase by 40% the number of chlamydia infections diagnosed and treated.
    - Until recently, there was no reliable test for chlamydia in males. Now both men and women can be tested and treated for the disease.

WHAT MONTANA HAS ACCOMPLISHED:

Over the past 10 years, significant public health efforts have succeeded in reducing the rates of the three most common STDs in Montana—syphilis, gonorrhea, and chlamydia.

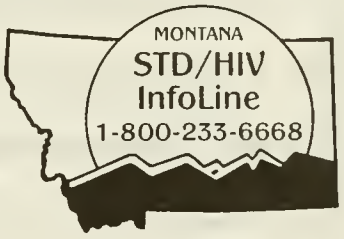
- ✔ DPHHS' STD/HIV Section supports 22 STD clinics statewide to provide access to testing and treatment for STDs and HIV status.
- ✔ Identifying sexual partners of infected persons is critical in reducing the incidence of STDs. The STD/HIV Section provides professional training, for both public and private health care providers, for STD interviewing and investigation.
- ✔ In 1997 and in 1998, DPHHS' STD/HIV Section has received federal awards for excellence to enable funding of special projects.

WHAT STILL NEEDS TO BE DONE:

- ❑ Increase screening tests of females who seek health care for routine reproductive issues. This additional screening would require a 50% increase in the numbers of tests and would take additional funding from the state.
- ❑ Test contacts who have been named by STD-infected individuals. When contacts named by the original patient are tested, other partners of those who test positive can be located and treated. This additional testing will require additional funds.
- ❑ Improve disease intervention among Native Americans. The chlamydia rate among Native Americans is about four times higher than among all Montanans. While this difference may be related to more extensive screening on Montana's reservations, more extensive screening in other areas, further testing of named contacts, and better public education can significantly reduce this rate.
- ❑ Educate young people regarding the risks of acquiring STDs and about prevention strategies. Since most cases occur in 15-19 year olds, youth need better understanding of STDs and better skills in delaying sexual activity or preventing STD transmission.

WHERE IT NEEDS TO BE DONE:

These goals can be accomplished through collaboration between the DPHHS' STD/HIV Section and Family and Community Health Bureau, local health departments, Planned Parenthood clinics, schools, the Indian Health Service, parents, and community organizations that build youth self-esteem and support safe, healthy choices.



FOR MORE INFORMATION, CONTACT:

STD/HIV Section
(406) 444-3565

HIV/AIDS TREATMENT

MONTANA GOAL AND OBJECTIVES:

Maintain the low incidence of HIV infection in Montana and make appropriate treatment options available to those who are infected.

- ❑ Continue present level of uninterrupted service to the 35 clients already in the Ryan White Title II program. Provide for medication changes as necessary to continue appropriate treatment.
- ❑ Stabilize funding and raise qualification income levels so that individuals may return to employment without jeopardizing funding for very high-cost medications.
- ❑ Add nine additional clients in 1998.
- ❑ Provide service for the anticipated three to six additional clients who will apply for this program annually.

New HIV drugs may delay the onset of AIDS indefinitely. They cost about $9,000 per year per patient.

Standard hospitalization for treatment of opportunistic infections as a result of AIDS can cost more than $1,000 per day per patient.

WHY IT'S IMPORTANT:

- The new treatments for HIV infection and AIDS have allowed many infected persons to return to a productive, healthier life.
  - The current treatments, can reduce HIV infection to an undetectable level in the individual, decreasing the chance of transmission to others and increasing the person's ability to continue employment.
  - For these treatments to be effective, they must be consistently available. Intermittent or occasional use of the new drugs can lead to drug-resistant strains of the virus. To protect all Montanans, we need to assure a reliable source of funding for all infected Montanans.
- These new treatments are very expensive. While the federally funded AIDS Drug Reimbursement Program currently pays for the needed drugs for a number of Montanans, there are still many who have no access, or only limited access, to the treatments.
- The current focus of health care is to reduce expenses by using more cost-effective prevention and treatment methods. Treatment of HIV is cost-effective, especially when it prevents the progression to AIDS or delays the development of AIDS-related infection. Intensive care hospitalization can cost more than $1,500 per day. Each subsequent AIDS-related infection further reduces the patient's resistance to invading infection and may result in more frequent treatment and hospitalizations. Often this expense is borne by the Medicaid program. Alternatively, hospitals and doctors are not compensated for AIDS patient care by any source, and the costs are shifted through across-the-board increases to insured and private-pay patients.

WHAT MONTANA HAS ACCOMPLISHED:

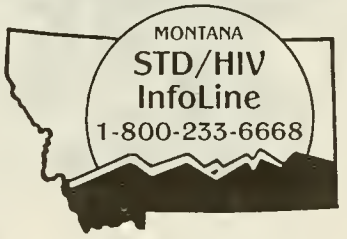
- ✔ DPHHS supports 14 sites for HIV testing and prevention.
- ✔ The STD/HIV Section operates a 24-hour toll-free information line where Montanans can receive information about HIV and STDs and where they may obtain testing and treatment.
- ✔ DPHHS' STD/HIV Section funds six consortia sites where HIV-positive clients receive case management services and assistance with locating necessary healthcare, housing, and nutritional support.
- ✔ With the increase in federal funds in 1998, eight persons have joined the Ryan White program, leaving a waiting list of nine persons.
  - ✓ The STD/HIV Section has successfully placed six individuals on temporary Patient Assistance Programs with national drug companies.
  - ✓ The STD/HIV Section is negotiating with the Office of Drug Pricing to obtain HIV drugs at a significantly reduced cost, thus enabling additional patients to be served.
- ✔ DPHHS supports education for healthcare providers regarding appropriate treatment of HIV disease. Providers in Montana may see very few HIV-positive clients and need the additional resources provided by state support staff.
- ✔ DPHHS provides technical assistance and training to private and public health professionals to improve HIV counseling and partner notification.

WHAT STILL NEEDS TO BE DONE:

- ❑ Identify those persons infected with HIV who have no other resources for treatment support. Refer those persons to appropriate medical care and support their need for drug treatment to the extent necessary, maximizing their continued ability to be self-supportng, tax-paying citizens.
- ❑ Identify what other basic support HIV infected individuals need to stabilize them and reduce the opportunity for transmission to others. Housing and basic nutritional support are critical to the success of the new treatment programs.
- ❑ Educate young people about the risks of HIV and about prevention strategies. Build better understanding of HIV and more skills in delaying sexual activity and/or preventing HIV transmission.

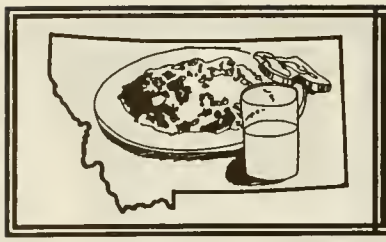
WHERE IT NEEDS TO BE DONE:

These goals can be accomplished through collaboration between the state STD/HIV Section and Family and Community Health Bureau, local health departments, Family Planning clinics, schools, the Indian Health Service, parents, and community organizations that build youth self-esteem and support safe, healthy choices.



FOR MORE INFORMATION, CONTACT:

STD/HIV Section
(406) 444-3565



FOOD SAFETY

MONTANA GOAL AND OBJECTIVES:

Increase the safety of food served to Montana's citizens and visitors.

- ❑ Update the existing foodservice regulations to substantively reflect the content of the 1997 Food and Drug Administration (FDA) Model Food Code by January 1, 1999.
- ❑ Increase by 10% the food safety training opportunities for inspection staff at the state and local level and for foodservice operators statewide by July 1, 1999.
- ❑ Standardize local and state food establishment inspection and plan review services by July 1, 1999.
- ❑ Revise the foodservice licensing fee system by December 31, 1999, to provide more adequate support for local food safety programs and to more equitably reflect the level of service provided to different types of establishments.

According to national statistics, about one in every 65 Montanans will be sickened by food-borne illness each year. (Source: CDC)

WHY IT'S IMPORTANT:

- When food service establishments are involved, one source of illness or bacteria can infect large numbers of people.
- While most of those affected by food-borne illnesses will be healthy again after a day or two of nausea/diarrhea, some will need hospitalization.
- The cost of food-borne illness is tremendous, as scarce public resources must cover lost wages, health care, and investigative costs.
- The majority of food-borne illnesses are caused by food kept at inappropriate temperatures, illness of food handlers, and unsanitary practices. Fortunately, most food-borne illnesses can be prevented.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ The Food and Consumer Safety Section of DPHHS established a Food Code Task Force to review the 1997 FDA Model Food Code. The task force membership predominately represents the foodservice industries in Montana.
- ✔ The task force, after completing its review of the 1997 FDA Model Food Code, recommended that the Food and Consumer Safety Section replace the existing foodservice and food processing regulations with a modified version of the Model Food Code that the task force has produced.
- ✔ DPHHS, the Montana State University Extension, and industry representatives have offered the nationally recognized "SERVSAFE" food safety training program. More than 40 county sanitarians and Extension Educators have been trained and certified as trainers to provide the "SERVSAFE" course to all levels of the foodservice industry.
- ✔ An interdepartmental planning team is developing a coordinated Hazard Analysis Critical Control Point (HACCP) training program for the food industry. Trainees will include food processing, manufacturing, and production plants; retail food sales and service; and consumers.
- ✔ Section staff provide training for county sanitarians at quarterly regional meetings and at the state-wide training conferences that are offered to all local sanitarians twice each year.

WHAT STILL NEEDS TO BE DONE:

- ❑ Complete the revision of the foodservice regulations based on the recommendations of the Food Code Task Force.
- ❑ Revise the Statutes for Food Establishments (50-50, MCA) to provide a system for assessing variable license fees based on the potential risk each type of food establishment may pose to the health of the public and that more clearly reflects the level of food safety inspection and education services required by different establishment types.
- ❑ Add one staff position to the Food and Consumer Safety Section to provide standardization training to all county sanitarians in the state. This training will assure a more consistent delivery of inspection and education services to the foodservice industry. This new position will also be actively involved in implementing the coordinated HACCP training program.

WHERE IT NEEDS TO BE DONE:

- ❑ The Food and Consumer Safety Section of DPHHS will request staffing and statutory changes to improve food safety inspection services.
- ❑ Section staff will work with the Food Code Task Force to modify food service rules.
- ❑ Qualified state and federal agency trainers will train county health department sanitarians, food industry managers, meat and poultry plant inspectors, and consumers.

FOR MORE INFORMATION, CONTACT:

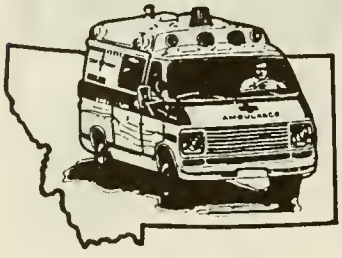
Food and Consumer Safety Section
(406) 444-5309

EMERGENCY MEDICAL SERVICES

MONTANA GOAL AND OBJECTIVES:

Assure the provision of prompt, effective emergency medical services and trauma care to Montana citizens and visitors through development of a comprehensive, integrated, statewide Emergency Medical Services (EMS) System.

- ❑ Establish a dedicated, statewide funding source to support state and local EMS education, training, and EMS and trauma system implementation by June 30, 2003.
- ❑ Ensure the emergency medical and trauma care systems are guided by quality improvement methods and standards and that operational and policy decisions are based on sound data. Establish statewide quality improvement standards, medical direction and quality improvement indicators by December 31, 2003.
- ❑ Assure a comprehensive emergency medical services education system that is carefully integrated with Montana's education system and provides excellent initial and ongoing education to Montana's EMS providers in a cost-effective and efficient manner. Implement a comprehensive EMS educational system by June 30, 2003.



Montana's Emergency Medical Services System is the "safety net" for Montana's citizens and visitors.

Whenever an automobile crash, a heart attack, a poisoning or any other unexpected medical emergency occurs, the EMS system must:

- be promptly available
- provide excellent care
- perform consistently under the most adverse conditions.

WHY IT'S IMPORTANT:

- An excellent EMS system reduces deaths, decreases the seriousness of injuries and lessens rehabilitation time. The scarcity of medical resources in rural areas, combined with long emergency transport distances, makes the availability of an excellent EMS system even more critical.
- Prehospital ground ambulance care is provided by 51 basic life support (BLS), 29 defibrillation, 24 intermediate level, and 21 advanced life support (ALS) services. This care is supplemented by 93 non-transporting services (29 ALS and 64 BLS), four ALS helicopter ambulance services, five ALS fixed-wing air ambulance services and one BLS fixed-wing air ambulance service.
- EMS services are primarily autonomous local units staffed by 4,500 prehospital care providers, many of whom are volunteers. The EMS and Injury Prevention Section of DPHHS trains local coordinators who conduct EMS education at the local level.
- A trauma care system, carefully integrated with the EMS system, can reduce preventable injury mortality by at least 20%. According to a recent study, Montana's current preventable injury mortality rate is about 17%.

WHAT MONTANA HAS ACCOMPLISHED:

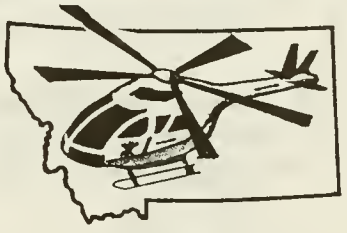
- ✔ Montana has an excellent EMT certification and testing system.
- ✔ Most Montana ambulance services are now staffed with at least EMT-Basic personnel.
- ✔ A CDC trauma system development grant is helping to establish a statewide trauma system -- a very important component of the emergency medical services system.
- ✔ The Montana Trauma System Plan has been adopted along with authorizing legislation.
- ✔ Three Regional Trauma Advisory Committees (RTACs) are active.
- ✔ The State Trauma Care Committee has been appointed and is operational.
- ✔ Trauma data on seriously injured patients are collected from nearly every Montana medical facility.
- ✔ With the assistance of an Emergency Medical Services for Children grant, DPHHS' EMS and Injury Prevention Section is leading the development of a statewide, data-driven, quality-improvement-based EMS system using a state-of-the-art computer data collection and reporting system. This will allow EMS providers and medical directors to evaluate care, identify performance indicators, and improve the quality of emergency care. Data grouped at the state level will guide state quality improvement, resource allocation, and planning and targeting of EMS education and injury prevention programs.
- ✔ Computers have been placed in nearly every Montana ambulance service; a prehospital EMS data collection software contract has been awarded. Data collection will support the evaluation and improvement of the quality of prehospital care.

WHAT STILL NEEDS TO BE DONE:

- ❑ Reduce death and disability from injury and illness by implementing and funding comprehensive EMS, trauma care and injury prevention programs.
- ❑ Align the trauma care plan and EMS system objectives with financial incentives from Medicaid, Medicare, and other third-party payers.
- ❑ Assure a more coordinated, comprehensive system that provides excellent and affordable EMS education. Promote improved coordination between the EMS system and public health programs.
- ❑ Increase the access of Montana citizens and visitors to advanced life support care and to defibrillation within the critical time for maximum effectiveness.
- ❑ Assure that emergency services have proper medical direction and oversight.
- ❑ Assure the statewide availability of excellent poison control services.
- ❑ Update EMS laws to assure consistency with new developments and to solve old problems including increasing the authority of state and local governments to avoid duplication of local EMS resources.
- ❑ Assure emergency medical service dispatchers have excellent training through a statewide emergency medical services dispatch training program.
- ❑ Assure permanent funding for the state Injury Prevention and Control Program and Trauma Care Programs and the statewide EMS delivery system.

WHERE IT NEEDS TO BE DONE:

Delivery of emergency medical services will occur at the local level with consistent and ongoing evaluation according to local and state quality improvement standards and performance indicators. There should be reasonable statewide regulation and oversight of EMS and trauma care while preserving regional and local operational flexibility. Coordination should be through the state Trauma Care Committee, the state EMS Advisory Council, and the Regional Trauma Advisory Committees.



FOR MORE INFORMATION, CONTACT:

Drew Dawson
EMS and Injury Prevention Section Supervisor
(406) 444-1814
ddawson@mt.gov

PUBLIC HEALTH LABORATORY

MONTANA GOAL AND OBJECTIVES:

Reduce the incidence of communicable disease in Montana through a surveillance system based upon public health laboratory disease diagnosis and assessment.

- ❑ Maintain at 100% the proportion of local health departments and other public clinics with access to accurate, reliable, population-based, public health laboratory services.
- ❑ Document the need for general fund financial support for the public health laboratory to offset the cost of laboratory services provided to publicly funded health care providers by December 31, 1998.
- ❑ Maintain the state's capacity to provide rare and technically difficult laboratory procedures to test for conditions that affect the health of Montanans.
- ❑ Integrate the laboratory data management system with emphasis on electronic reporting capabilities by December 31, 1999.

The Montana Public Health Laboratory is staffed seven days per week and conducts an average of 230 tests per day.

It will conduct at least 84,000 tests in fiscal year 1998.

WHY IT'S IMPORTANT:

- The primary function of a public health laboratory is to provide support for public health programs. Unlike a private clinical laboratory, Montana's Public Health Laboratory is concerned with the health of the community as a whole, not just that of individual patients.
- The department has a responsibility to protect the public from the spread of infectious diseases and conditions that affect their health.
    - Early identification of disease conditions by the Public Health Laboratory assures appropriate treatment and limits or prevents the spread of disease.
    - Identification of populations at increased risk of illnesses gives policy makers information for reducing the burden or spread of illness.

WHAT MONTANA HAS ACCOMPLISHED:

The primary public health functions of a state Public Health Laboratory are:

- ✔ Examination of specimens to identify disease outbreaks by isolation and identification of a causative agent.
- ✔ Testing for diseases of public health significance, such as tuberculosis, which are too rare and unusual to be identified by other laboratories.
- ✔ Provision of confidential, low-cost testing for diseases, such as those transmitted sexually, which are prevalent in populations not likely to approach private health care providers.
- ✔ Population surveillance testing such as newborn screening for metabolic disorders.
- ✔ Research to discover new and emerging pathogens, such as toxin-producing *E. coli*, in what is or may become an outbreak situation.
- ✔ Centralization of data for rapid transmission to epidemiologists, infectious disease specialists, and other health policy decision makers.
- ✔ Reference services such as viral isolation and identification, including those of rare and unusual microorganisms which a local laboratory cannot identify.
- ✔ Training of private clinical laboratory personnel throughout the state.

WHAT STILL NEEDS TO BE DONE:

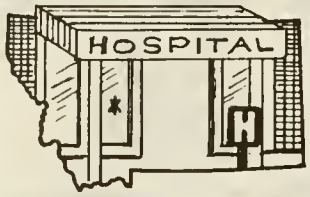
- ❑ The Public Health Laboratory must enlist from all facets of the health care system support for and recognition of its place in assuring the health of the public. The laboratory needs to:
  - Remain on the cutting edge of laboratory technology to meet the growing need for preventive services and to maintain the ability to identify rare and emerging diseases.
  - Evaluate new testing procedures with public health significance for possible addition to the current test menu.
  - Maintain a laboratory fee schedule competitive with private industry while continuing to help local public health care providers protect the health of their community at affordable costs.

WHERE IT NEEDS TO BE DONE:

The maintenance of low-cost laboratory services, full testing capacity, and leading edge technology is a state agency responsibility. Montana's small, rural hospitals and all the public health clinics rely on the state Public Health Laboratory to fulfill that responsibility. The laboratory is a resource to rural hospitals, providing services that they do not have the capacity to perform. It is a partner with public health clinics, offering laboratory testing services with competitive pricing.

FOR MORE INFORMATION, CONTACT:

Laboratory Manager
Public Health Laboratory
(406) 444-3444



ACCESS TO HEALTH CARE

MONTANA GOAL AND OBJECTIVES:

Assure that all Montanans have access to basic health care: preventive, as well as curative, medical and dental services.

- ❑ Improve access to health care services in Montana so that by December 31, 2000:
  - At least 90% of children have access to a primary care provider and health insurance or coverage by a health care plan.
  - At least 90% of Montana's two-year-old children are fully immunized.
  - At least 60% of non-institutionalized and 80% of institutionalized Montanans age 65 and older are fully immunized.
- ❑ Improve baseline data on access to and use of primary care services by December 31, 1999, to provide local and state decision makers with consistent, county-level information on access to care.

The consequences of inadequate or intermittent health care include *serious physical risks for Montana families* and *avoidable, high-cost, acute care that is publicly funded.*

WHY IT'S IMPORTANT:

- Access to health care services is limited by the ability to pay for those services and the availability of those services within the community.
  - DPHHS estimates that 20,000 children of low-income working parents in Montana have no health insurance coverage or health plan.
  - Annual statewide surveys from 1991 through 1995 reveal approximately 16% of Montanans reported no health insurance coverage or health plan.
  - In 1995, among those Montanans surveyed whose household income was less than $20,000, 26% had no health care plan.
- Appropriate use of health care services is limited by the understanding of the need for and availability of those services.
  - Almost 64% of the survey respondents age 65 or older said they had received a flu shot within the past 12 months.
  - Only 35% of respondents age 65 or older said they had received a pneumonia vaccination.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ Eleven National Health Service Corps (NHSC) providers were placed in rural Montana settings in 1997.
- ✔ Fifteen counties have applied through the DPHHS Primary Care Office for Health Professional Shortage Area and/or Medically Underserved Area status.
- ✔ More than 60 family practice physician residents and medical, nurse practitioner, and physician assistant students were placed with experienced Montana professionals to learn about health care practice in rural and frontier settings.
- ✔ Almost 87% of Montana's two-year-olds were fully immunized in 1997—an 11% improvement over the 1996 immunization rate.
- ✔ DPHHS is working with the Health Care Financing Administration (HCFA) and MPQHF to remind Medicare patients of the need for pneumonia vaccinations and annual flu shots.
- ✔ The Medicaid Passport to Health program has seen only 1% total growth in the cost of physician services since 1993.
- ✔ The Certificate of Need (CON) program has published the 1997 State Health Care Facilities Plan to give health care providers guidance for determining the feasibility of developing or expanding health care services.

WHAT STILL NEEDS TO BE DONE:

- ❑ Improve access to public and private health care services, especially for at-risk populations and geographical areas lacking adequate coverage.
  - ■ Increase reimbursement for Medicaid providers to assure access.
  - ■ Assure persons eligible for publicly financed health care services are aware of their eligibility.
  - ■ Assure publicly financed health care services are efficiently and effectively used.
- ❑ Expand immunization programs to include 11 to 12 year olds and adults at risk for pneumonia and influenza.
- ❑ Help communities and the state analyze their health status and resource needs, planning and developing health services based on sound data.
  - ■ Develop a revolving loan repayment program to make start-up funds available to communities to enhance their basic, direct health services.
  - ■ Initiate a federal NHSC State Loan Repayment Program with state dollar match for education loan repayment incentives to bring non-physician providers into medically underserved areas.
  - ■ Develop legislation aimed at further streamlining the CON program's requirements and deadlines. Create a special revenue account of CON-generated fees for programmatic and legal costs incurred by the program.

WHERE IT NEEDS TO BE DONE:

DPHHS' Health Policy and Services Division, particularly the Primary Care Office, Certificate of Need Program, Immunization Section, and Medicaid Services Bureau, will work with communities to improve their access to health care, especially for:

- ❑ Areas with a high proportion of the population who are poor; have high infant mortality rates; or are age 65 or older.
- ❑ Areas with inadequate health care services.

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MANAGED CARE

MONTANA GOAL AND OBJECTIVES:

Improve the quality of managed care.

- ❑ Establish a quality assurance program for Medicaid, Medicare, and commercial health maintenance organization (HMO) participants by October 1, 1999.
- ❑ Assure consumer and provider protection from inappropriate health services by implementing MCA 33-36-101 through 33-36-402.
  - ■ Develop DPHHS administrative rules to regulate and monitor the managed care network and assure the adequacy of managed care services by October 1, 1999.
- ❑ Facilitate a productive working relationship with Montana's HMOs.

DPHHS has a responsibility to Montana citizens and visitors to assure that managed care organizations operating in the state provide high-quality, appropriate, and timely services.

WHY IT'S IMPORTANT:

- ❑ As HMOs continue to penetrate the market in Montana, the public interest in HMO plan performance has increased. DPHHS must assure the **quality** of the following critical components of managed care organizations:
  - ■ HMOs permit and encourage their service providers to diagnose and prescribe appropriate, timely treatment.
  - ■ Managed care consumers have a way to evaluate and judge plan performance.
  - ■ Consumers have recourse and DPHHS has a means of ensuring improved performance if managed care performance is below standard.
  - ■ Guidelines are in place and functioning as quickly as possible to avoid the mistakes other states have made in the managed care arena.
  - ■ There is consistency in reporting among managed care organizations throughout the state.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ **The governor, DPHHS, and the insurance commissioner successfully supported Senate Bill 365 (MCA 33-36-101 through 33-36-402) which ensures network adequacy and quality assurance in managed care.**
  - ✓ DPHHS formed an advisory committee to assist HPSD to develop administrative rules for managed care network adequacy and quality assurance.
  - ✓ The Medicaid Services Bureau developed draft network adequacy rules and presented them to the advisory committee for comment.

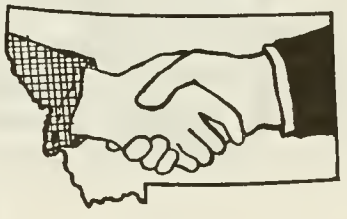
- ✔ MCA 33-36-101 through 33-36-402 directs DPHHS to regulate health insurance carriers who offer managed care plans in Montana, consumer and provider protection, and a regulatory enforcement mechanism for compliance.
  - ✓ DPHHS has primary responsibility for developing the network adequacy and quality assurance rules and implementing the requirements of this law.
  - ✓ DPHHS is developing an internal system to facilitate the implementation of rules, regulations, monitoring, and procedures to assure compliance.

WHAT STILL NEEDS TO BE DONE:

- ❑ Finalize and adopt administrative rules for managed care network adequacy.
- ❑ Draft and adopt administrative rules for managed care quality assurance and quality improvement.
- ❑ Adopt quality assurance reporting criteria for Medicaid, Medicare, and commercial managed care organizations.
- ❑ Develop reporting mechanisms to generate managed care quality assurance information.
- ❑ Monitor managed care services in the state and report noncompliance to the insurance commissioner, who will enforce the statute and rules.
- ❑ Provide education to managed care organizations, legislative entities, and Montana citizens about Medicaid, Medicare, and commercial requirements for compliance with network adequacy and quality assurance rules and regulations.
- ❑ Obtain approval and funding for staff to administer the program.

WHERE IT NEEDS TO BE DONE:

Responsibility for ensuring consistency of standards and quality of care rests with DPHHS. The HPSD advisory group assisting in the development of rules and reporting requirements includes Montana HMOs; hospital, medical, primary care, and other associations; and citizen advocacy groups, American Association of Retired Persons (AARP), and other interested persons. DPHHS will develop reporting mechanisms and educational materials and procedures for statewide use, relying on the participation of its advisory group to represent national and local public and private concerns.



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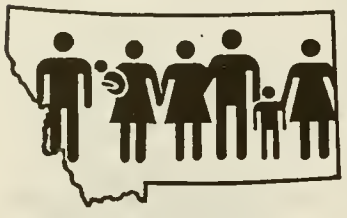
PUBLIC HEALTH IMPROVEMENT

MONTANA GOAL AND OBJECTIVES:

Strengthen our capacity to protect Montanans against communicable and chronic diseases, injury, and environmental threats to health.

- ❑ By June 2001, implement a Public Health Training Institute with defined public health competency requirements as the basis for its core curriculum, serving 85% of the public health personnel statewide.
- ❑ By December 2000, develop and recommend revisions to the Montana Code to assure the delivery of 100% of the core public health functions at the state and local level.
- ❑ By June 2001, increase to 60% the proportion of local agencies that fulfill the public health roles and responsibilities outlined in the Montana Public Health Improvement Plan and defined by Montana law.
- ❑ By December 2002, increase to 60% the proportion of local agencies that have a public health improvement plan that includes:
  - An assessment of the community's capacity to meet ongoing and emergency health and safety needs.
  - A comprehensive health coalition with participants from local health, education, business, labor, charitable or religious, and government organizations.
  - At least an annual, completed community health needs assessment.
  - Identified outcome, cost, and other evaluation measures to monitor plan implementation.



Health costs in the U.S. *increased* by more than *210%* between 1981 and 1993.
Funding for improving the health of the population *decreased 25%* in that time.

Nationwide, 41% of state public health funding is provided by the state. In Montana, state funds account for 15% of state public health funding.

WHY IT'S IMPORTANT:

- A strong public health system:
  - Focuses on **preventing** premature death and disease.
  - Controls health care costs through protection before the fact instead of treatment afterwards.
  - Provides the **least expensive** health care costs per capita.
- Erosion of financial support has led to erosion of local ability to provide for the health and safety of community residents and visitors. That reduction in local capacity in Montana became the focus of a statewide conference on public health and health care reform in 1994.
- The Governor's Public Health Improvement Task Force identified the following critical areas for building local capacity:
  - Support for local improvement projects and Healthy Communities.
  - In-state training for local and state public health professionals.
  - Clarification of public health statutes defining public health and local and state roles and responsibilities.
  - Streamlining of public health financial and program reporting.
  - Identification of the related roles of public health and health service systems such as managed care.
  - Information to the public about what public health is and does.

WHAT MONTANA HAS ACCOMPLISHED:

- ✔ 1995—The Montana Legislature passed the Public Health Improvement Act, and Governor Racicot established a Public Health Improvement Task Force (PHITF).
- ✔ 1996—The PHITF published The Montana Public Health Improvement Plan identifying the current health status of Montanans, core public health functions, local and state agency roles and responsibilities, and recommendations for public health improvement.
- ✔ 1996—DPHHS reformed the PHITF as an agency advisory committee and identified those items in the Public Health Improvement Plan that DPHHS would undertake with current funding.
- ✔ 1997—DPHHS and four county coalitions received Robert Wood Johnson and Kellogg Foundation "Turning Point" grants to increase the **capacity** of Montana's public health system to meet changing health needs; promote **collaboration** among government agencies, community organizations, and individuals; and improve **accountability** for the Montana public health system's decisions and actions.
- ✔ 1998—DPHHS and the PHITF, assisted by the Turning Point grant and technical assistance, are:
  - ✓ Beginning to identify the capacity of local public health agencies to meet the highest priority health needs of their communities.
  - ✓ Developing a Public Health Training Institute to improve state/local capacity to meet those needs.
  - ✓ Supporting and participating in Montana's state and local Healthy Communities projects.

WHAT STILL NEEDS TO BE DONE:

- ❑ Continue to support local public health improvement initiatives and encourage replication of local successes.
  - ■ Assist local coalitions in developing pilot Turning Point, public health improvement, and Healthy Communities projects.
  - ■ Help make successful projects permanent and use them as demonstration programs for other Montana communities.
- ❑ Work with local public health agencies to develop and implement an ongoing, self-sustaining system of assessment and improvement.
  - ■ Improve the ability of state and local agencies to identify and prioritize community needs and determine and monitor the costs of public health.
  - ■ Improve county assessment, performance, and budget reporting systems.
- ❑ Develop public information strategies to explain and promote public health improvement initiatives.
- ❑ Monitor changes to health service systems and define the impact on the health of the public and on the responsibilities of public health agencies.
- ❑ Review Montana law relating to public health to:
  - ■ Identify redundancies and gaps in legal mandates and responsibilities.
  - ■ Organize public health laws around the core functions of public health.
  - ■ Revise existing laws, such as that covering food establishment licensure and fee structure, to meet the changing needs of both the highly mobile urban population and the most remote rural one.

WHERE IT NEEDS TO BE DONE:

The public health capacity needs strengthening in each of Montana's counties and at the state level. At the state level, the Public Health Training Institute, public health programs, the Montana Turning Point Initiative, and data integration projects will support community public health improvement efforts.

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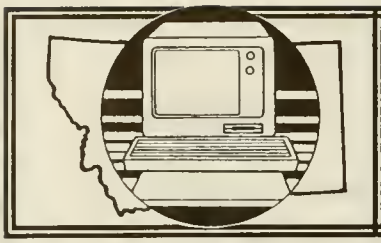


INFORMATION ACCESS AND SECURITY

MONTANA GOAL AND OBJECTIVES:

Integrate public health data systems.

- ❑ By August 31, 1999, implement a comprehensive Public Health Data System (PHDS) for all local health departments. The PHDS will help local health professionals document and coordinate health services and will make information easily available to local decision makers to improve the health of the public.
- ❑ By December 31, 1999, complete a Common Local Intake system to link the PHDS with the other health data systems used in Montana's cities and counties. The Common Local Intake will facilitate local information sharing where authorized by clients so it can be used to protect and improve the health and safety of city and county residents.
- ❑ By May 1, 2000, develop an IDEA Information Center. De-identified information will be extracted from the local-level health information and linked with extracts from DPHHS health data systems. The resulting information base will provide health information while preserving client confidentiality.
- ❑ By July 1, 2002, complete full-scale training, support, and evaluation of the data system integration project and develop electronic links with private health care providers to add de-identified information about immunizations, births, infant and child health, and other information about the health of the public.

City and county health professionals must use more than *15 separate data systems* for information about services and clients of Montana's public health programs and Medicaid.

An integrated data system will provide local public health providers with:

- Efficient client intake.
- Improved coordination of services among programs.
- Elimination of duplicate services such as blood tests and client health assessments.

WHY IT'S IMPORTANT:

- Separate local data systems often require local staff to enter duplicate data and maintain separate records on the same clients.
- In addition to the unnecessary work, duplicate data entry means that local health professionals have no direct method of evaluating the overall effect of multiple programs or of coordinating program activities for clients and families.
- The Health Policy and Services Division began the Integrated Data for Evaluation and Assessment (IDEA) project to integrate local and statewide systems. The project is designed in four phases—with emphasis first on local integration to improve services to families and communities and to facilitate local policy making and program planning. IDEA will mean:
  - More time spent on the health of the public instead of on data manipulation.
  - Improved administration, evaluation, and management of local public health programs.

WHAT MONTANA HAS ACCOMPLISHED:

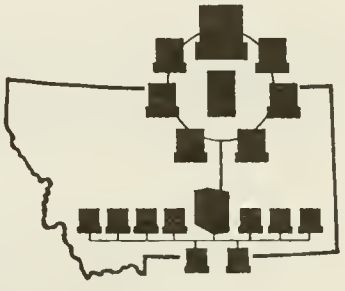
- ✔ Beginning in 1996, the IDEA project team completed an analysis of system and user needs and developed a project plan. The project was designed in phases to ensure the most effective use of existing resources and to provide the maximum immediate benefit to the counties.
- ✔ In 1997, the Montana Legislature authorized the use of federal funds to implement the IDEA data integration project statewide. Project planning included:
  - ✓ Formation of a Data Integration Advisory Council, a Confidentiality Subcommittee, and targeted small working groups.
  - ✓ Definition of local system needs through a requirements analysis; a survey of other states' integration efforts; and a careful review of off-the-shelf software products which might, with customization, serve as the basis for the county Public Health Data System.
- ✔ HPSD applied for and received federal funding, including two highly competitive awards, to carry the IDEA project through the first four phases.
- ✔ In 1998, DPHHS issued a Request for Proposals to purchase and customize software for the PHDS.

WHAT STILL NEEDS TO BE DONE:

- ❑ Complete each of the four phases of the IDEA project.
- ❑ At the county and state levels, link de-identified records to provide "profiles" of client characteristics, program services, and health outcomes. Aggregate these profiles for analysis of the health status and needs of Montana's population. This capability will provide for the following:
  - ■ Improved public health programs for ensuring the safety and health of Montana's population.
  - ■ Better understanding of the impact of programs on each other and on the people they serve.
  - ■ A clearer, more complete picture of program costs and effects required for the most informed and effective decision making at both the client and the health department levels.
  - ■ Most effective use of scarce resources.
- ❑ Remain active in the national dialogue and benefit from sharing of strategies, successes and lessons. Most states are developing data integration solutions to meet their information needs. While every state has a different approach, the issues and answers have much in common.

WHERE IT NEEDS TO BE DONE:

Documenting the IDEA system needs, planning, and carrying out the project plan are statewide efforts. Participants include county health departments and commissioners, state legislators, local and state health program and systems experts, Indian Health Service and tribal health department representatives, software development consultants, representatives of parent groups, and concerned citizens. Most of the related public health data systems are fielded by the Health Policy and Services Division of DPHHS, which is taking the lead in this project.



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ACRONYMS AND GLOSSARY

AARP — American Association of Retired Persons, a national organization whose membership is open to anyone 50 or more years of age.

AIDS — acquired immuno-deficiency syndrome, a stage of HIV infection defined by the presence of opportunistic infections, certain tumors, and/or levels of function of the immune system.

ALS — advanced life support.

BCHP — Breast and Cervical Health Program, a CDC-funded DPHHS program providing comprehensive breast and cervical cancer screening, education, and diagnostic services to eligible women.

BLS — basic life support.

BRFSS — Behavioral Risk Factor Surveillance System, a nationwide CDC-funded system of telephone surveys of adults to evaluate health risks in the population. The BRFSS is carried out, in Montana, by DPHHS.

CDC — federal Centers for Disease Control and Prevention.

CHIP — Child Health Insurance Plan, a federal and state program to enhance access to health care for Montana's children in low-income working families who have previously been uninsured.

CVD — cardiovascular disease, a general term describing diseases of the heart and blood vessels.

CON — Certificate of Need, a DPHHS program that approves or disapproves health facility and service proposals to develop or expand certain health care services.

COPD — chronic obstructive pulmonary diseases, including asthma, emphysema, bronchitis, and bronchiolitis.

categorical program, categorically funded program — a self-contained program, often separately funded, that focuses on a specific area of need (that is, category). Examples are "Tobacco Free Montana," the "Montana Diabetes Project," and the "Montana Initiative for the Abatement of Mortality in Infants."

DEQ — Montana Department of Environmental Quality.

DPHHS — Montana Department of Public Health and Human Services.

EMS — emergency medical services, including ground and air ambulance services; basic, intermediate, and advanced life support; and defibrillation.

EPSDT — Early & Periodic Screening, Diagnosis and Treatment, a program that brings comprehensive health care to children from birth to 21 years of age who are eligible for Medical Assistance. This program has a preventive health philosophy of discovering and treating health problems before they become disabling and costly in both human and financial terms.

early prenatal care — medical care for a pregnant woman that begins within the first trimester (the first three months of pregnancy).

E. coli — ***Escherichia coli***, a bacterial infection generally caused by contamination of food by the colon bacillus.

FAIM — Families Achieving Independence in Montana, a welfare reform program implemented in 1996 incorporating Food Stamps, AFDC, and Medicaid. The goals of FAIM include strengthening the values of family, work, and responsibility while increasing recipients' personal dignity on their way to achieving self-sufficiency.

FDA — federal Food and Drug Administration.

FICMR — Fetal/Infant/Child Mortality Review, a community-based program with the goal of preventing fetal, infant, and child deaths.

goal — as used in this document, a five-to-10 year outcome for Montana's population.

HACCP — Hazard Analysis Critical Control Point training program being developed by a state government team including DPHHS' Food and Consumer Safety Section.

HCFA — Health Care Financing Administration, the federal agency that is responsible for administering Medicare and overseeing states' administration of Medicaid.

HIV — human immunodeficiency virus, a viral infection that weakens the immune system.

HMO — health maintenance organization, a system for providing comprehensive health care to large groups of enrolled members in a specific geographic area. Members must use providers that belong to the HMO network and choose a personal care physician to oversee their care.

HPSD — Health Policy and Services Division of DPHHS.

high school education — a high school diploma or General Education Degree (GED).

IDEA — Integrated Data for Evaluation and Assessment, a DPHHS project to provide integrated, easily accessible data at the county and state levels, with the primary focus on the county-level data systems.

MCA — the Montana Code Annotated, Montana state law.

MCHB — federal Maternal and Child Health Bureau.

MDP — Montana Diabetes Project, a CDC-funded DPHHS program for the prevention and control of diabetes.

MIAMI — **M**ontana's **I**nitiative for the **A**batement of **M**ortality in **I**nfants, a program providing prenatal services and information for high risk pregnant women.

MPQHF — **M**ountain-**P**acific **Q**uality **H**ealth **F**oundation, a private Montana-based health research, care review, and data processing organization.

managed care — comprehensive medical care with an emphasis on prevention. The managed care philosophy is that it's better to manage health care services to help keep people well, than to wait to treat them after they become ill.

median — the mid-point in a range. For example, half of the persons in a population are at or below the median age for that population and half are at or above the median age.

Medicaid — a federal entitlement program administered and operated by participating states that provides medical benefits to eligible low-income persons needing health care.

Medicare — a nationwide, federally administered health care program, usually for patients 65 and older, that provides medical, surgical, and hospital care.

NCHS — National **C**enter for **H**ealth **S**tatistics.

NHSC — National **H**ealth **S**ervice **C**orps.

neonatal period — the first 27 days of an infant's life.

newborn — an infant in the first 27 days of life.

OPI — Montana **O**ffice of **P**ublic **I**nstruction.

objective — as used in this document, a short- or mid-term milestone that is measurable in terms of both achievement and time. Achieving an objective indicates successful progress toward a long-range goal. A synonymous term is "benchmark."

PHITF — the Montana Public Health Improvement Task Force, appointed by Governor Racicot in 1995 and reformed in 1996 as an advisory committee to DPHHS.

per capita income — the total income of a specific population, divided by the number of persons in that population, regardless of their age or employment status.

performance measure — the a statistic or standard that provides the means of determining whether an objective has been achieved.

perinatal transmission of HIV — transmission of HIV during pregnancy from the infected mother to the fetus.

poverty level — the income threshold used by the U.S. Bureau of the Census to determine the poverty status of individuals, families, and households. For the 1990 census, the average poverty threshold for a family of four persons was $12,674 total income in 1989. Specified poverty levels are obtained by multiplying the

income cutoff by the poverty level factor. For example, the average income cutoff for 185% of poverty was $23,447 ($12,674 x 1.85) for a family of four in 1989.

RTAC — **R**egional **T**rauma **A**dvisory **C**ommittee; Montana's trauma system has three RTACs.

SIDS — sudden infant **d**eath syndrome, the unexplained death of infants, usually during sleep.

STD — sexually **t**ransmitted **d**isease.

TRY — **T**ake **R**esponsibility for **Y**ourself, a program to encourage children to improve physical activity and dietary practices.

Turning Point Initiative — a project funded at the state level by the Robert Wood Johnson Foundation and in four Montana communities by the Kellogg Foundation. The Initiative seeks to increase the capacity of Montana's public health system to meet changing health needs, to promote collaboration among agencies and organizations interested in improving the health of the public, and to improve accountability for publicly-funded health system decisions and actions.

WIC — Special Supplemental Nutrition Program for **W**omen, **I**nfants and **C**hildren funded by the U.S. Department of Agriculture.

Y.A.H.O.U — **Y**oung **A**dults **H**elping **O**thers **U**nderstand, a program supporting projects planned and coordinated by adolescent students that focus on tobacco use prevention.

YRBS — **Y**outh **R**isk **B**ehavior **S**urvey, a CDC-funded survey of 7th through 12th grade students. OPI conducts the YRBS every other year in Montana's middle and high schools.

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Priorities for a Healthy Montana

- Cardiovascular Disease
- Cancer
- Unintentional Injury
- Pregnancy Outcomes
- Child and Adolescent Health
- Unintended Pregnancy
- Diabetes
- Sexually Transmitted Diseases
- HIV Treatment
- Food Safety
- Emergency Medical Services
- Public Health Laboratory Services
- Access to Health Care
- Managed Care
- Public Health Improvement
- Information Access and Security

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